HEALTH UPDATE FORM

Student Name:	
Student's Physician:	Phone:
Student's Dentist:	Phone:
Preferred Hospital:	
Does your child have any of the following allergies?	
Bee Sting: ☐Yes ☐No	Type of reaction:
	Treatment:
Food or Nut: ☐Yes ☐No	List:
	Type of reaction:
	Treatment:
Environmental: ☐Yes ☐No	List:
	Type of reaction:
	Treatment:
Other Allergies: ☐Yes ☐No	List:

Has your child had any illness, injury, or operation during the past year?	☐ Yes ☐ No
(specify with dates)	
Does your child take any medications on a daily or regular basis?	☐ Yes ☐ No
Please list:	
Vision: ☐ Glasses ☐ Distance ☐ Reading ☐ Worn constantly ☐ Contact Lenses	
Other Vision Problems:	
Hearing: ☐ Frequent Infections ☐ Tubes ☐ Known hearing loss ☐ Right ☐ Left ☐Both ☐ Hearing Aid ☐ Cochlear Implant ☐ Classroom FM System	
Are there any other issues the nurse should now be aware of?	☐ Yes ☐ No
Please specify:	

In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary, including transportation to the hospital in case of emergency.

Signature of parent/guardian _____ **Date**_____.