CF Schools Health Update

School Year 20___ to 20___

Please complete the following information and return to the health office. This information needs to be updated annually for your student's health and safety.

Student Name: Last: _____ First: _____ Middle: _____

DOB: _____ Grade: _____ Gender: _____ Parent/Guardian: _____

Please record any health concerns or medications that the health office should be aware of.

Concerns	Yes	No	Comments	Yes	No
Allergies (food, medication, environmental)			Takes Medication for Allergies		
Allergic to:			Has Epipen?		
Attention Deficit Disorder (ADD)			Takes Medication for ADD?		
Attention Deficit Hyperactivity Disorder (ADHD)			Takes Medication for ADHD?		
Asthma			Takes Medication for Asthma?		
Seizures			Takes Medication for Seizures?		
Diabetes			Takes Medication for Diabetes?		
Skin Disorders			Takes Medication for Skin Disorders?		
Heart Condition / Murmur			Heart condition:		
			Restrictions:		
Hospitalizations / Operations			Date(s) / Reason(s):		
Serious Illnesses / Injuries			List / Explain:		
Other medical		I	ist / Explain:		
Wears glasses / contacts			Other concerns/information for health office: (may continue on reverse side)		
Hearing Loss					

Medications currently taking:	Takes at Home	Takes at School	Takes at Home & School	Notes:

Do you have health insurance for your student? (check one) ☐ Yes ☐ No

Insurance Company: _____

Has your student been out of the country for a period of **30 days or longer** within the past year? ☐ Yes ☐ No

CONFIDENTIAL RELEASE OF INFORMATION

Student's Physician:	(name / location):
Student's Dentist:	(name / location):
Student's Eye Doctor:	(name / location):

I give specific permission to the school nurse and dental hygienist to conduct health screening and to share as deemed appropriate with school staff and staff from Black Hawk County's I-Smile Program. This information sharing would be deemed appropriate if it directly affects my student's learning, well-being, and/or safety at school (this may include referrals for health services as needed). I give permission to the school nurse and/or dental hygienist to exchange information with the above listed health professionals for the purpose of referral, diagnosis, and/or treatment.

Parent / Guardian Signature: ✔ _____ Date: ✔ _____