Black Hawk County Schools Health Update **School year 2016 to 2017**

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: _____

Birth Date: _____ Grade: _____Sex: _____

Parent/Guardian: _____ Address: _____ Zip: _____

Father's Name: _____Phone #: _____ Cell #:_____
Workplace: _____ Work #: _____

Mother's Name: _____Phone #: _____ Cell #:_____
Workplace: _____ Work #: _____

Emergency Contacts: 1. _____ Relationship: _____Phone #: _____
2. _____ Relationship: _____Phone #: _____

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

Concerns	Yes	No	Comments
Allergies (food, medication, environmental)			Allergic to: Has Epipen? Yes ☐ No ☐
Attention Deficit Disorder			Takes Medication? Yes ☐ No ☐
Asthma			Takes Medication? Yes ☐ No ☐
Seizures			Takes Medication? Yes ☐ No ☐
Diabetes			Takes Medication? Yes ☐ No ☐
Skin Disorders			
Glasses/Contacts			
Hearing Loss			
Heart Condition/Murmur			Condition: Restrictions:
Hospitalizations/Operations			Date/Reasons:
Serious Illnesses/Injuries			List/Explain:
Other			

Medications currently taking:	Takes at Home	Takes at School	Takes at Home and School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Turn Over and SIGN

Other concerns or information: _____

Do you have health insurance for your student? _____Insurance Company: _____

Has your student been out of the country for a period of 30 days or longer within the past year?
Yes_____ No_____

HEALTH SCREENING

Your School Nurse, Health Assistant, and Black Hawk County Public Health Dental Hygienist may periodically conduct screenings for height, weight, vision, blood pressure and dental health throughout your student's school years according to their age / class group.

CONFIDENTIAL RELEASE OF INFORMATION

Student's Physician: _____

Student's Dentist: _____

Student's Eye Doctor: _____

I give specific permission to the school nurse and dental hygienist to conduct health screening and to share information 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 treatment.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____