MSAD No. 75 Annual Student Health Update Form

Student Name: _____ **Birth Date**: _____ **Grade**: _____

Does your child wear glass/contact lenses?	☐ Yes	☐ No	Does your child have hearing problems or wear hearing aids?	☐ Yes	☐ No

Please list your child's allergies: _____

Are they life threatening? ☐ Yes ☐ No **Epipen prescribed?** ☐ Yes ☐ No

Please list any chronic health problem(s) your child is diagnosed with (i.e. asthma, diabetes, seizure disorder, heart condition, ADD/ADHD, or other chronic health condition). Please use the back of paper if needed.

List date(s) of any head injury or concussion your child has had diagnosed by a physician:

List any hospitalizations (including mental health), surgery, major illness or injury your child has had in the past year:

List your child's current medications:

Will your child need to take a prescribed medication during the school day? ☐ Yes ☐ No

Do you consent to a written or verbal exchange of information between your child's primary care physician and the school nurse for medical purposes? This will include but not be limited to: immunization records, medication orders, asthma action plans, seizure action plans, bee sting allergy action plans and physical exams. **Please note medication orders, allergy and asthma plans, as well as health plans, must be updated annually.**

☐ Yes ☐ No **Primary Care Provider**: _____

Primary Care Provider Ph: _____ **Primary Care Provider Fax:** _____

Do you need assistance finding dental care for your child? ☐ Yes ☐ No **Dental Provider:** _____

****For Mt. Ararat Middle School and High School Students ONLY** For minor aches, pains and headaches.**

Permission for dose appropriate ibuprofen	☐ Yes	☐ No	Permission for dose appropriate Tylenol (acetaminophen)	☐ Yes	☐ No

Parent/Guardian Signature: _____ **Date**: _____

Parent/Guardian Printed Name: _____

Revised 04/13/2022