

# West Irondequoit Central School District

## Confidential Student Health Information Update

(To be completed by parent/guardian)

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

### MEDICAL HISTORY: Please check any health condition(s) that pertains to your child.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Elevated Blood Pressure     | <input type="checkbox"/> Hearing/Ear concern  |
| <input type="checkbox"/> Bladder/Kidney Problem | <input type="checkbox"/> Emotional concern           | <input type="checkbox"/> Heart problem/Murmur |
| <input type="checkbox"/> Blood disorder         | <input type="checkbox"/> Fainting spells             | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Dental problems        | <input type="checkbox"/> Fracture/Dislocation/Injury | <input type="checkbox"/> Vision/Eye concern   |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Other: _____         |

Please explain your child's specific needs for any checked areas: \_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES AND TREATMENT REQUIRED: List all specific allergens.

Food: \_\_\_\_\_

Bees/Insects: \_\_\_\_\_

Medications: \_\_\_\_\_

Environmental/Other: \_\_\_\_\_

Are these allergies Life Threatening? \_\_\_\_\_

Usual treatment: \_\_\_\_\_

### MEDICATIONS: Please list any prescription or non prescription medication taken on a regular basis. Information about medications is included in the student's cumulative health record which is kept on file in the Health Office.

At Home: \_\_\_\_\_

At School: \_\_\_\_\_

Please indicate below, which School Personnel you would like to be aware of your child's medications.

*All medications administered at school require written parental consent and a physician's order. Please obtain a current medication form from the school nurse if/when your child needs medication in school. All medication will be kept in the School Health Office for administration by the nurse. All students who self carry medication must also submit a "Parent and Prescriber's Request For Student Self Medication" to be kept on file in the School Health Office.*

### PERMISSION: Please read the following three areas and include your signature as appropriate.

*I give my permission for the School Nurse to inform the appropriate Building Administrators, Faculty, Special Services, and Emergency Medical Services of my child's health information and needs.*

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*Please specify below which additional School Personnel should be informed and instructed about your child's health needs.*

Teacher Assistant    Bus Driver    Cafeteria    Lunch Monitor    Coach    Trainer   Other \_\_\_\_\_

*I do not give permission for my child's health information to be disclosed to School Personnel.*

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*I have read and reviewed the Confidential Student Health Information Update form and do not have any information to report at this time.*

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_