

Greenfield Public Schools School Health Services ANNUAL STUDENT HEALTH UPDATE

Student's Name: _____ Date of Birth _____

School: _____ Grade: _____ Teacher: _____

Home Address: _____

Parent/Guardian Name #1: _____ Parent/Guardian Name #2: _____

Phone #1: _____ #2: _____

Student Lives With: Both Parents ____ One Parent (specify): _____ Other (specify): _____

Student's Legal Guardian: Both Parents ____ Guardian (specify) _____ Other (specify) _____

Emergency Contact (in case we are unable to reach you): Name _____ Telephone _____

Pediatrician's Name _____ Dentist's Name _____

Has your child had a routine physical examination within the past 12 months? YES / NO (If your child is in Pre-K, K,, grades 4, 7, 10 or new to this school system, please be sure to forward a copy of the most recent physical examination to the school nurse.)

Does your child have any of the following health problems or concerns?

Health condition	Yes	No	If Yes, please describe:
Asthma			
Diabetes			
Convulsive/seizure disorder			
Bleeding problem			
Skin condition/Birthmark			
Recent surgery			
Eye/vision problem			
Wears glasses			For reading, distance or both
Ear/hearing problem			
Seasonal allergies			
Food allergy:			Epipen?
Bee sting allergy			Epipen?
Behavior problem or ADHD			Medication?
Other			

My child has health insurance YES NO Name: _____

My child has dental insurance YES NO Name: _____

Is your child currently taking any medications other than what you have listed above? YES NO

Please list medications and reason for use:

May this health information be shared with appropriate school staff? YES NO

I give permission to have my child taken to the nearest emergency facility. YES NO

I give permission to the school nurse to communicate with my child's health care provider regarding pertinent medical information. YES NO

May the school administer the following if necessary? YES or NO in each box

Acetaminophen	Ibuprofen	Bactine	Aloe Gel	Tums	Calamine Lotion	Cough Drops	Anbesol	Bacitracin	First Aid Cream	Sting Kill	Epipen
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In the event of frequent requests for Acetaminophen or Ibuprofen, an order from the student's Primary Healthcare Provider will be required.

Parent/Guardian Signature: _____ Date: _____