Prairie Hill Elementary School Health Services/School Year 2009/2010

Information Update For Your Child's School Nurse

Dear Parents,

We would like to provide the optimum care for your child therefore we are requesting some additional information that may not have been included on the Pupil Emergency Card. This form will be confidential and kept in your child's health record in the Health Office. Please provide the most current information. Should anything change after filling out and handing in this form please notify the school nurse.

STUDENT NAME: _____, _____ _____ _____ _____

Last **First** **Middle** **Birthday** **Age**

Has your child's vision been tested outside of school? __ Yes __ No **Does your child wear glasses? ____Yes ____No**

If **Yes,** results of:

Normal: ___ Other: _____

Date of exam: _____

Last glasses or contacts Rx change: _____

Surgery: _____Date:_____

Has your child's hearing been tested outside of school? __ Yes __ No

If **Yes**, results of:

Normal: ___ Other: _____

Date of exam: _____

Hearing aids? _____

Surgery: _____ Date: _____

Any medications your child is currently taking at home?

Medication: _____ Dose: _____ Time(s) given: _____

Medication: _____ Dose: _____ Time(s) given: _____

Medication: _____ Dose: _____ Time(s) given: _____

Medication: _____ Dose: _____ Time(s) given: _____

Does your child have an allergy to any foods, medications, insects, latex, or other substances? ___ Yes ___ No

If **Yes**, please list in detail: _____

Please circle if allergy is **severe** **moderate** **mild** List symptoms: _____

What medications or treatments are used to treat the allergy? _____

Has your child ever had a severe anaphylactic reaction requiring emergency care (list date)? _____

Please check all that apply to your student:

( ) Allergies (seasonal)	**( ) Dyslexia/Learning Disorder**	**( ) Muscular/Orthopedic Disorder**
( ) ADHD	**( ) Eating Disorder**	**( ) Pervasive Developmental Disorder**
( ) Asthma(please list triggers below)	**( ) Epilepsy/Seizure Disorder**	**( ) Psychiatric Psychological Disorder**
( ) Chicken Pox – Date: _____	**( ) Heart Condition**	**( ) Serious Accident/Head Injury**
( ) Cystic Fibrosis	**( ) Hearing Problems**	**( ) Surgery**
( ) Diabetes	**( ) Kidney Disorder**	**( ) Vision Problems**
( ) Down Syndrome	**( ) Migraine Headaches**	**( ) Other: _____**

If yes to any of the above, describe:_____

Please note any concerns of which the school nurse needs to be aware:_____

Signature of Parent or Guardian: _____ **Date:** _____