

**Green Island Union Free School District
Annual Student Health Update Form 2018-19**

Name of Student _____ M ___ F ___ Date of Birth _____ Grade: _____

Please take a moment to provide the school nurse with all the necessary health information that will allow her to provide prompt quality care to your child and help your child maximize his/her academic potential in the classroom.

Does your child have a physician? Yes No Name: _____ Phone # _____

Does your child have any of the following health problems:

Allergies: Yes No Please list: _____
Please describe child's reaction: _____

EpiPen ordered? Yes No

Asthma Yes No If on medications, please list: _____

Diabetes Yes No If on medications, please list: _____

Seizures Yes No If on medications, please list: _____

Bleeding Problems Yes No Please explain: _____

Eye/Vision Problems Yes No Wears Glasses/Contacts **Yes No**
For reading books ___ For seeing distance ___ Both ___

Ear/Hearing Problems Yes No Right ear ___ Left ear ___ Both ___

Please explain: _____

Mental Health Problems/ Diagnosis- Yes or No- If yes, please explain _____

Any other current or past health problems? Yes No

For example. frequent stomachaches, headaches, constipation, kidney problems, lactose intolerance, skin problems, foot or knee problems, cardiac condition, weight concerns, dietary concerns, broken bones or sprains ? Please explain:

Has your child had any recent surgeries? Yes No Please list: _____

Is your child taking any medication on a regular basis? Yes No

Name of medication(s):

Reason for use:

Signature of Parent/Guardian _____ Date _____