

# A. CROSBY KENNETT MIDDLE SCHOOL

## ANNUAL HEALTH INFORMATION UPDATE – Year 2011/2012

**BOTH SIDES TO BE COMPLETED BY PARENT / GUARDIAN AND RETURNED TO THE SCHOOL NURSE ASAP**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
(print LAST name) (print FIRST name)

Parent/guardian daytime contact telephone number \_\_\_\_\_  
(Name) (Phone)

Please complete the following checklist and give details below (attach any additional pertinent information).

**Does the student currently or had in the past, any of the following conditions?**

|  | YES | NO |  | YES | NO |
|--|-----|----|--|-----|----|
| <b>Allergies</b> / seasonal, food, environmental , bee, insect sting (specify allergen & reaction below) |     |    | Gastrointestinal Condition   |     |    |
| Is an Epipen required? (please contact Nurse)  |     |    | Bladder / Kidney Condition   |     |    |
| Does he/she carry Epipen at all times? <b>Where?</b>   |     |    | Head Injury / Concussion (date)  |     |    |
| Medication Reaction / Allergy (list below)   |     |    | Skin Condition   |     |    |
| ADHD / ADD (list medication below)   |     |    | Orthopedic / Bone /Neck  |     |    |
| Asthma (PLEASE carry inhaler & contact nurse)  |     |    | Cancer / Leukemia  |     |    |
| Diabetes (contact Nurse for plan of care)  |     |    | Hearing Loss / Correction  |     |    |
| Seizures (date of last episode, list medication)   |     |    | Vision Loss / Correction   |     |    |
| Headaches/Migraines (list medication)  |     |    | Speech Condition   |     |    |
| Bleeding/Clotting Disorder (specify)   |     |    | Eating Disorder  |     |    |
| Psychological/Psychiatric (please specify condition and prescribed medication)                           |     |    | Chickenpox (history of disease provide month/year or immunization documentation) |     |    |
| Heart Condition  |     |    | Other (explain below)  |     |    |

**Please give details and dates to all of the above marked YES.**

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Is the student taking any **medication** on a regular basis (prescription or non-prescription)? \_\_\_\_ YES \_\_\_\_ NO  
**List the medication, dose, times and reasons for taking.** \_\_\_\_\_

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Is the student currently under any kind of **medical care or treatment**? \_\_\_\_ YES \_\_\_\_ NO  
**Explain** \_\_\_\_\_

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**Contact the school nurse to make arrangements for any medication to be given in school.**

**All prescribed medications that require administration during the school day must be accompanied by an MD order. Medication is to be kept in the Nurse's Office, although, some students may carry their prescribed inhalers, Epipens and diabetic supplies.**

