Complete 1 per child

GHV Community School District
Annual Student Health Update

Student Name: ______________________________________ Gender: M F

Birthdate: ____________________ Grade: ____________ Building:__________

Parent/Guardian Name(s): ____

Family Doctor:	Date Last Seen:
Eye Doctor:	Date Last Seen:
Wears Glasses?	Wears Contacts?
Dentist:	Date Last Seen:
Specialty Doctor:	Date Last Seen:
Specialty Doctor:	Date Last Seen:

Medication Taken Regularly	Dosage	How Often	Condition Medication is Taken For

Allergies (medication, food, environmental, latex, etc.)	What Type of Reaction

Current Illness: List any illness, injury or surgeries occurring since last school year, including the date they occurred:____

____

____

Chronic Illness or Conditions that may affect school performance: List any health conditions such as asthma, migraines, seizures, diabetes, hearing problems, ADHD, behavioral, etc.:____

____

____

Immunizations:

____To the best of my knowledge my child's immunizations are up-to-date (please initial).
****7th and 12th Grade Students**: ALL students entering 7th grade, need to have a Tdap and Meningitis booster, prior to the first day of school. All students entering 12th grade need to have a Meningitis booster prior to the first day of school.**

Please turn over and complete page 2

Complete 1 per child

INSURANCE

Does student have:

_____ Private Insurance (List Name)________________________________

______Medicaid

_____ HAWKI

_____ No Insurance

_____ Other (List Name) ________________________________

PERMISSIONS

Elementary-High School: Please complete all 4 questions

In case your child is ill or injured at school or during a school event out-of-town, and we think he/she needs medical attention, do you grant school personnel permission to do so?

Yes________ No________

If student's health care provider is not available, may we send him/her to another local provider?

Yes________ No_________

I give my child permission to receive Tylenol/Acetaminophen for complaints of discomfort at school from the school nurse and/or trained school personnel at their discretion for this school year.

Yes________ No________

Over-the-Counter Medication: I give permission for the use of cough drops, topical antibiotic ointment (Bacitracin), contact solution, Benadryl, Calagel or normal saline eye drops as needed by the discretion of the health office and/or trained school personnel.

Yes________ No________

MIDDLE SCHOOL & HIGH SCHOOL ONLY: I give my child permission to receive Motrin for complaints of discomfort or Tums for complaints of stomach upset at school from the school nurse and/or trained school personnel at their discretion for this school year. Yes_________ No_________

MEDICATION POLICY

I understand that my child can receive prescription medications at school through School Health Services. I understand that the medication must be in the original container with all the information current to what the child receives. **I understand that a Medication Permission form must be signed and accompany the medication.** ***This form can be obtained from the Health Services office in the school building your child attends***. **Please see www.ghvnurses.weebly.com for proper form. May return electronically. **

NOTICE: The school does NOT assume financial responsibility for medical/dental bills incurred as a result of illness or school accidents.

NOTICE: Student's health information is shared with appropriate staff in accordance with the District's policy/procedure and applicable laws of confidentiality. Information is shared on a "need to know" basis with school personnel who supervise students.

Parent/Guardian Signature:_________________________________ Date:__________