

# Black Hawk County Schools Health Update

School year 20\_\_ to 20\_\_

Please complete the following information and return to the health office. This information needs to be updated annually for your student's health and safety.

Student Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_ Phone #: \_\_\_\_\_ Mom's Cell #: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_ Dad's Cell #: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Daytime #: \_\_\_\_\_ Workplace: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Daytime #: \_\_\_\_\_ Workplace: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Emergency 1. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Contacts: 2. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Student's Physician: \_\_\_\_\_ Last examination: \_\_\_\_\_ Findings: \_\_\_\_\_  
 Student's Dentist: \_\_\_\_\_ Last examination: \_\_\_\_\_ Findings: \_\_\_\_\_  
 Student's Eye Doctor: \_\_\_\_\_ Last examination: \_\_\_\_\_ Findings: \_\_\_\_\_

Please record any health concerns or medications that the health office should be aware of.

Concerns	Yes	No	Comments
Allergies (food, medication, environmental)			Allergic to: Name of Medication: Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/> Name of Medication: Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/>
Attention Deficit Disorder			Has Epipen? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Medication: Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/> Name of Medication: Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/>
Asthma			Name of Medication: Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/>
Seizures			Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/> Name of Medication:
Diabetes			Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/> Name of Medication:
Skin Disorders			Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/> Name of Medication:
Glasses/Contacts			Takes at Home <input type="checkbox"/> ; Takes at School <input type="checkbox"/> ; Takes at Home and at School <input type="checkbox"/>
Hearing Loss			
Heart Condition/Murmur			Condition: Restrictions: Date/Reasons:
Hospitalizations/Operations			Date/Reasons:
Chicken Pox			Date:
Serious Illnesses/Injuries			List/Explain:
Other			

Other concerns or information: \_\_\_\_\_

Do you have health insurance for your student? \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Has your student been out of the country for a period of 30 days or longer within the past year?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**HEALTH SCREENING**

Your School Nurse and Health Assistant may periodically conduct screenings for height and weight, vision, blood pressure, dental health and spinal screening throughout your student's school years according to their age / class group.

**CONFIDENTIAL HEALTH INFORMATION AND COMMUNICATION RELEASE**

I give my permission to the school nurse to share information with school staff that has a need to know that is relevant to my student's health and safety needs. I give permission to the listed medical professionals to exchange information for the purpose of referral, diagnosis, and treatment with the School Nurse.

I give specific permission to my health care providers to conduct health screening and share any pertinent health information in my student's health record regarding: Immunizations, Administration of Medications, and/or Educationally Significant Health Information that may affect my student's learning and/or safety at school.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_