WESTERN SCHOOL CORPORATION

Annual Health Update

Student Name ____ Grade ________

Physician's Name(s) ____

****

PLEASE "X" ALL HEALTH CONDITIONS WHICH APPLY TO YOUR CHILD:

☐No known Health Problems

☐Asthma

- **☐Uses Inhaler**
- **☐Will Require Inhaler at School**
- **☐Hospitalized in last year for asthma**

☐Allergies

- **☐Bee/Insect Sting**
- **☐Foods –LIST: ____**
- **☐Medications—LIST: ____**
- **☐Other: Please Comment Below**
- **☐Epi-Pen Needed for Allergy Listed Above**

☐Seizures

- **☐Currently on Medications**

☐Other: Please Comment Below

☐Diabetes

☐Heart Condition

☐Physical or Birth Defect

☐Wears Glasses/Contacts

☐Known Hearing Loss

Additional Comments/Concerns: ____

____

____

****

MEDICATION SCHEDULE:

Please List All Prescription Medications Your Child is Taking: ____________________

____

Please List Those to be Taken at School: _______________________________________

____

****

The above information CAN be shared with faculty, coaching staff, and your child's bus driver. Select "YES" below if you want this information shared with those who work with/coach your child. If you do NOT want this information shared, please select "NO" below. With this selection, information will be kept confidential with the nurse in your child's building.

☐YES ☐NO

____ ________________

Signature of Parent/Guardian **Date**