

**IROQUOIS CENTRAL SCHOOL DISTRICT**

**Annual Student Health History Update**

**Dear Parent/Guardian:** Please complete this form and return it to the School Nurse

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Male  Female

Name of Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**CHECK HERE IF THERE ARE NO CHANGES FROM LAST YEAR AND SIGN AT BOTTOM.**

▪ Does this child have an ongoing health concern? (Asthma, diabetes, etc.)  Yes  No  
If "yes", please describe: \_\_\_\_\_

▪ Does this child have any allergies?  Yes  No  
If "yes", please list: \_\_\_\_\_

▪ Is there a history of any hospitalizations, significant injuries or surgery?  Yes  No  
If "yes", please describe: \_\_\_\_\_

▪ Are there any current medical concerns/injuries?  Yes  No  
 Head \_\_\_\_\_  Eyes \_\_\_\_\_  Nose \_\_\_\_\_  
 Ears \_\_\_\_\_  Throat \_\_\_\_\_  Neck \_\_\_\_\_  
 Chest \_\_\_\_\_  Respiratory \_\_\_\_\_  
 Cardiovascular \_\_\_\_\_  Gastrointestinal \_\_\_\_\_  
 Genitourinary \_\_\_\_\_  Neurological \_\_\_\_\_  
 Musculoskeletal (include any fractures, etc.) \_\_\_\_\_

▪ Does this child take any medication regularly at home?  Yes  No  
If "yes", please describe: \_\_\_\_\_

▪ Does this child require medication at school?  Yes  No  
If "yes", please describe: \_\_\_\_\_

▪ Please list any additional concerns or information: \_\_\_\_\_  
\_\_\_\_\_

▪ Who lives with the child in his/her primary household? \_\_\_\_\_  
\_\_\_\_\_

▪ Does child spend a significant amount of time in another household?  Yes  No  
If "yes", please describe: \_\_\_\_\_

▪ Who has legal custody of this child? \_\_\_\_\_

▪ Describe any custody arrangements: \_\_\_\_\_

▪ If there are any additional concerns or pertinent information please use the back of this form.

**EMERGENCY MEDICAL AUTHORIZATION:** In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent to the administration of emergency medical treatment by any licensed physician/dentist and to transport my child to any reasonable accessible hospital facility. This information may be shared with School Personnel who are involved with my child.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Health Insurance: \_\_\_\_\_