

# Smithville School District Elementary Health Record Update

## For School Year: \_\_\_\_\_

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following form and return it to the school nurse

Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
(last) (First) (MI)

Grade: \_\_\_\_\_

**Medical History:** Check all those that apply:

<input type="checkbox"/> ADD	<input type="checkbox"/> ADHD	<input type="checkbox"/> Depression (Dr. diagnosed)
<input type="checkbox"/> Anxiety Disorder (Dr. diagnosed)		<input type="checkbox"/> Diabetes: Pump / Pen / Syringe
<input type="checkbox"/> Asthma		<input type="checkbox"/> Drug Allergy
<input type="checkbox"/> Autism	<input type="checkbox"/> Aspergers	<input type="checkbox"/> Food Allergy
<input type="checkbox"/> Bipolar Disorder		<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
<input type="checkbox"/> Blood Disorder		<input type="checkbox"/> Hearing Impairment/Aids
<input type="checkbox"/> Bone/Joint Disorder		<input type="checkbox"/> Heart Disorder
<input type="checkbox"/> Bowel Disorder / Incont.		<input type="checkbox"/> Kidney / Urinary / Incont. Disorder
<input type="checkbox"/> Cancer		<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Cerebral Palsy		<input type="checkbox"/> Migraines
		<input type="checkbox"/> OCD <input type="checkbox"/> ODD
		<input type="checkbox"/> Other Allergy
		<input type="checkbox"/> Respiratory Impairment
		<input type="checkbox"/> Scoliosis
		<input type="checkbox"/> Seizure/Neurological Disorder
		<input type="checkbox"/> Skin Disorder
		<input type="checkbox"/> Stomach Disorder
		<input type="checkbox"/> Tourette's Syndrome
		<input type="checkbox"/> Vision Disorder
		<input type="checkbox"/> Other

**Note:** It is the responsibility of the parents/guardians to provide physician documentation (including an Emergency action plan) for all significant diagnoses such as: Asthma, Food Allergy, Seizure, Diabetes, and others.

Please explain any conditions checked above and any special care required. Note if conditions are current or no longer an issue:

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List any surgeries or hospitalizations (please list dates):

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Do you believe your child has a physical or mental impairment that substantially limits a major life activity in the school environment? **YES / NO**

If yes, please explain the condition and how it substantially limits your child:

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Please list any medication(s) your child takes and reason for taking:

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**If a student is to receive medication at school, a separate form will need to be completed.**

**NOTE:** Epinephrine administration is Board approved and will be administered in the event your child is thought to be experiencing an anaphylactic reaction

While medical information is confidential, I understand the school nurse and other school staff may at times deem it necessary to share a student's information, including district health update forms as supplied by the parent with other school personnel, including but not limited to, teachers, administrators, transportation and cafeteria staff. As a parent I may also share information as I deem appropriate with my child's teacher, bus driver or other specific staff member independent of the school nurse or other school staff sharing this information

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_