

## Pardeeville Area School District Annual Student Health Update

School Year \_\_\_\_\_

School \_\_\_\_\_

Student Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Grade \_\_\_\_\_

Does your child have any of the following as diagnosed by a physician? (Please circle YES or NO)

Yes	No	Asthma—past / present / inhaler at school
Yes	No	Diabetes Insulin Required: Yes No
Yes	No	Heart Problems: _____
Yes	No	Cancer: _____
Yes	No	High Blood Pressure
Yes	No	Rheumatoid Arthritis
Yes	No	Bleeding Problems
Yes	No	Seizure Disorder: Frequency _____
Yes	No	Migraine Headaches
Yes	No	Scoliosis
Yes	No	Vision Problems: ___Glasses ___Contacts
Yes	No	Hearing Problems: Hearing Aid <u>  R  </u> <u>  L  </u>
Yes	No	Attention Deficit Hyperactivity Disorder (ADHD) / Attention Deficit Disorder (ADD)
Yes	No	Depression/Anxiety
Yes	No	Concussion
Yes	No	Surgeries List _____

Yes	No	Insect Sting Allergy
		Insect: _____
		Reaction: _____
		Treatment: _____
Yes	No	Allergies to Medications
		List: _____
		_____
Yes	No	Food Allergies (Severity/Specifics)
		Food: _____
		Reaction: _____
		Mild / Moderate / Severe – circle one
		Treatment: _____
Yes	No	Seasonal/Other Allergies
		List: _____
		_____
Yes	No	Other Health Problems
		List: _____

**IF YOUR CHILD HAS A DIAGNOSED MEDICAL CONDITION – PLEASE CONTACT THE SCHOOL HEALTH AIDE, BARBARA ALLEN 608-429-2151, ext. 149  
SCHOOL NURSES, LORETTA SMITH/BONNY OESTRICH 608-429-2153, ext. 236**

Please list the medications that your child is taking (i.e., inhalers, insulin, antidepressants, etc.)

	Medication Name	Dose	Time Taken	Purpose
1				
2				
3				
4				
5				
6				

If your child needs to take medication during school hours, the parent/guardian must sign a Medication Request/Consent Form. **Prescription medications and some non-prescription medications require a doctor's signature.** Forms can be obtained from the office or online at [www.pardeeville.k12.wi.us](http://www.pardeeville.k12.wi.us). Students **are not allowed** to carry medications with them unless it has been approved by the physician and parent (i.e., inhaler, epi-pens, glucagon). Questions can be directed to the school nurse/health aide.

\*The above information is correct to the best of my knowledge. Should changes occur, I will notify the school to ensure appropriate understanding of my child's health status. It will be shared with appropriate school staff to assure a safe environment for my child.

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

Date \_\_\_\_\_