ANNUAL PRESCHOOL HEALTH UPDATE FORM

Student Name:		**Date:**		
DOB:	**Male:** _______	**Female:** _____	**Age:** ____	**Grade:** ___________
Doctor:	**Eye Dr:**			
Dentist:	**Specialists:** *(Allergies, Heart, Etc.)*			

Medications:	**Respiratory Problems:**	**Allergies:**
Daily:	[ ] Asthma/Reactive Airway Disease	[ ] None
	[ ] Asthma/Allergy Action Plan	[ ] Seasonal/Hay Fever
	[ ] Inhaler [ ] Nebulizer	[ ] Insect/Bee Stings
	[ ] Other ______________________________	[ ] Food/Meds
As Needed:	**Heart Problems:**	[ ] Animals
	[ ] Murmur [ ] Congenital Defects	[ ] Epi Pen
	Other/Treatment ________________________	[ ] Action Plan
Nutritional/Metabolic Problems:	**Behavioral Problems/Psychiatric Disorders:**	**Stomach/Intestinal Problems:**
[ ] Anorexia/Bulimia [ ] Over/Underweight	[ ] ADD/ADHD [ ] Depression [ ] Bi Polar	[ ] Gastric Reflux/Heartburn
[ ] Special Diet ____________________	[ ] Oppositional/ Defiant [ ] Autism	[ ] Constipation
[ ] Other ________________________	[ ] Anger/Aggressive Behaviors	[ ] Other/Treatment:
Treatment: ______________________	Explain: ___________________________	
Endocrine DIsorders:	**Orthopedic Problems:**	**Blood Disorders:**
[ ] Diabetes Onset (yr) _____________	[ ] Scoliosis [ ] Recent Fraccture (past yr.)	[ ] Anemia [ ] Hemophilia
[ ] Hypoglycemia [ ] Thyroid Problems	[ ] Osgood-Schlatters [ ] Activity Restriction	[ ] Leukemia [ ] Frequent Nosebleeds
[ ] Other________________________	[ ] Other ______________________________	[ ] Other/Special Needs ________________
______________________________	______________________________	______________________________
GU Conditions:	**Neuromuscular Disorders:**	**Congenital Conditions:**
[ ] Wetting accidents [ ] Kidney Stones	[ ] Dizzy/fainting spells - date of last __________	[ ] Cleft Palate/Lip
[ ] Severe Menstrual Pain	[ ] Convulsions/Seizures - date of last ________	[ ] Down's Syndrome
[ ] Kidney/Bladder - frequent infections	[ ] Frequent headaches [ ] Migraines	[ ] Growth Disturbances
[ ] Other/Special Needs ______________	[ ] Meds ______________________________	[ ] Other/Needs _______________________
______________________________	______________________________	______________________________
Eye Disorders:	**Hearing Disorders:**	**Other Conditions:**
[ ] Blind - Right / Left / Both Eyes (circle one)	[ ] Hearing Loss - Right / Left / Both (circle one)	[ ] Development Delay [ ] Speech Problems
[ ] Eye Surgeries [ ] Glasses/Contacts	[ ] Hearing Aids [ ] Tubes	[ ] Learning Disability [ ] Skin Problems
[ ] Lazy Eye - Right / Left [ ] Other	[ ] Frequent Infections	[ ] Eczema [ ] Burns - severe [ ] Cancer
______________________________	[ ] Other ______________________________	[ ] Surgeries (past yr.) __________________
Treatment: ______________________	______________________________	[ ] Head Injury/Concussion When (yr) ________
		Explain ______________________________

	DTaP/DTP/DT	Polio	HIB	Hep. B	MMR/MMRV	Varicella	Pneumococcal	Influenza (Opt)
Dates of Immunizations	1.________	1.______	1.________	1.__________	1.__________	1.__________	1.__________	1.__________
	2.________	2.______	2.________	2.__________			2.__________	
	3.________	3.______	3.________	3.__________			3.__________	
	4.________						4.__________	

Parent/ Guardian Contact Info	Name: ______________________	Home: ______________	Cell: ________________
	Work #: _____________________	Email: ______________________________	
	Name: ______________________	Home: ______________	Cell: ________________
	Work #: _____________________	Email: ______________________________	

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

As a parent/guardian, I understand that medications of any kind are not allowed on school property and that school staff, including the nurse, MAY NOT administer or assist with any medications without the proper medical authorization on file. The information about my child's condition may be shared with appropriate school officials.

I, the parent/guardian, give my permission for Giltner Schools to administer ibuprofen or acetaminophen to my child named above. I understand that should my child have a reaction or any ill effects from the above medication, the school and/or employee's will **not** be held liable.

Parent/Guardian Name (print) ________________________________ (signature) ________________________________

Revised 10/29/2020