BENADIVES ISD ANNUAL HEALTH REVIEW PG 1 OF 2 SCHOOL YEAR:____________________

CONTACT INFORMATION

Student Name: ______________________________ Date: ______________ Birth date: ________________ Grade:__________

Parent Info: Mother: Name: ______________________________ Home/cell: ______________________ Work: ____________________
Email: ______________________________
Father: Name: ______________________________ Home/cell: ______________________ Work: ____________________
Email: ______________________________

HEALTH REVIEW

Breathing Problems	Heart Problems	Psych/Neuro Problems	Eating Problems	Gland Problems	Orthopedic Problems	Chronic/Developmental Problems
___ Asthma	___ Heart Murmur	___ Frequent Headaches	___Ulcer	___ Diabetes	___Broken bones	___ Cerebral Palsy
___ Reactive Airway	___ Heart Surgery	___ Migraines	___ Frequent stomach aches	___ Thyroid	___ Orthopedic braces	___ Downs Syndrome
___ Other Problems	___ Other Problems	___ Dizziness/Fainting	___ Bowel Problems	___ Kidney	___Other Problems	___ Spina Bifida
		___ Seizure	___ Special Diet at school			
		___ ADHD/Autism				
		___ Anxiety/Depression				

Please explain any items checked above: ____
____
____

Any Dr. ordered (***IF SO PLEASE CONTACT NURSE – NEED TO FILL OUT ADDITIONAL FORMS***) special needs:
____

Significant allergies:____________________ Treatment:____________________ Medications/Epi-Pen?(***requires Dr. order***) ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

List any illnesses, operations, or accidents your child has had in the past year: ______________________________
____
____

List other health concerns you would like the nurse to know about: ______________________________

Has your child lived outside of the United States during the past year? _____ Yes ______ No If yes, name of country: ____________________

MEDICATIONS

Current medications taken at home: ______________________________ ______________________________
______________________________ ______________________________

Current medications taken at school: ______________________________ ______________________________

(medications taken at school require a doctor's order IF PRESCRIPTON AND IF OTC REQUIRES PARENTAL PERMSSION WITH DETAILS – IF YOUR CHILD IS TO TAKE ANY TYPE OF MEDICATOIN AT SCHOOL PLEASE SEE THE NURSE – ADDITIONAL FORMS NEED TO BE FILLED OUT.

EMERGENCY INFORMATION: Doctor name: ______________________________ Phone: ______________________________
Hospital preference: ______________________________

I give permission to the school nurse to share educationally relevant health and emergency information (to included medical diagnosis) with school staff on a need-to-know basis. Parent signature: ____ Date: