Brunswick School Department
HEALTH UPDATE

Student's Name _____ DOB_____ Grade_____

PLEASE CHECK ALL THAT APPLIES TO YOUR CHILD

☐ADD/ADHD ☐Heart Condition

☐Migraines ☐Asthma

☐Mental Health ☐Seizure Disorder /Epilepsy

☐ Scoliosis ☐Diabetes

☐ Other chronic Health concerns (specify) _____

☐Allergies (food, medication, environment, insects) Explain _____

Epi-Pen used? Yes_____ No_____ Benadryl used? Yes_____ No_____

IN THE PAST YEAR, HAS YOUR CHILD… (Please explain all yes responses below)

had any serious illness? Yes_____ No_____

had any serious injuries? Yes_____ No_____

had mental health problems? Yes_____ No_____

been hospitalized? Yes_____ No_____

had surgery? Yes_____ No_____

Comments: _____

_____

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

At Home_____

At School_____

Physician_____ Dentist_____

Hospital Preference: _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's physician for the purpose of referral, diagnosis and treatment.

_____ _____

Parent/Guardian Signature Date

(5/03)