

Elementary/Upper Elementary
Carlisle School Annual Health Review **School Year** _____

Student Name _____ **Date** _____ **Birth Date** _____ **Grade** _____

Parent Contact Numbers: **Mother: Name** _____ **Home** _____ **Cell** _____ **Work** _____
E-mail _____ **Place of work** _____ **Lives with mother**
Father: Name _____ **Home** _____ **Cell** _____ **Work** _____
E-mail _____ **Place of work** _____ **Lives with father**

If the primary and secondary contacts cannot be reached, whom should we contact?

Name: _____ Relationship _____ Phone number _____
Name: _____ Relationship _____ Phone number _____
Name: _____ Relationship _____ Phone number _____

Health Review

Breathing Problems	Heart Problems	Neurologic Problems	Eating Problems	Gland Problems	Orthopedic
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Stomach Problems/Ulcer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Reactive Airway	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizure	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Orthopedic Braces
<input type="checkbox"/> Other Problems	<input type="checkbox"/> Other Problems	<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Special Diet at School	<input type="checkbox"/> Kidney	<input type="checkbox"/> Other Problems

Dr. Ordered Special Needs (please attach): Glasses/Contacts Hearing Aids Seat Close to Instruction Liberal Bathroom Privileges Physical Education Limits

List Your Child's Allergies: **Food** _____ **Medicine** _____ **Environmental** _____

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

List any emotional, social, or other conditions that might affect your child's school performance: _____

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

Current Medications: _____ **Medications to be given at school:** _____

Emergency Information: **Doctor Name:** _____ **Number:** _____ **Hospital of Preference:** _____
Dentist Name: _____ **Number:** _____

*****In case of serious accident and illness at school, your child will be sent to an emergency medical facility. The parent(s)/guardian is responsible for all expenses.**

Health Insurance Information: Private Medicaid Hawk-i No Insurance **Dental Insurance:** Yes No

Health Information/ Screening: The school nurse may share educationally relevant health and emergency information (to include medical diagnosis) with school staff on a need to know basis. During the course of the school year we will do screenings for vision and hearing. Grade levels included in the screening are determined annually. The vision screening is conducted by the school nurse and the hearing screening is conducted by AEA.

Parent/Guardian Signature _____ **Date** _____