

SCHOOL DISTRICT OF SPRINGFIELD TOWNSHIP

CERTIFIED SCHOOL NURSING SERVICE

HEALTH HISTORY UPDATE

NOTICE TO PARENTS/GUARDIANS:

Please complete this form and return as soon as possible. The new information you provide will help keep your child's health records current. **We are especially interested in events or developments within the PAST year or since you last filled out a health history form.** Thank you!

Child's Name _____ Telephone _____

Birthdate _____ Grade _____ Teacher _____

Family Doctor _____ Telephone _____

PLEASE COMPLETE ALL ITEMS:

1. Allergies (food, dust, pets, etc.) :

2. Under doctor's care for:

Needs while in school:

3. Injuries/Operations/Hospitalizations (within the last two years):

4. Medications:

DAILY medications _____

AS NEEDED medications: _____

- Periodically takes medication for _____
- Rescue inhaler needed in school?: Yes No
- Other medication needed in school?: Yes (please specify, _____) No

Note: If your child requires any medication while at school, a medication form needs to be on file in the school nurse's office. Please consult your school nurse and/or the SDST website for further information regarding the Medication Policy.

6. Date of last physical exam _____ Significant findings _____

Note: Please provide the school nurse with a copy of your child's shot record any time they receive additional vaccinations.

7. Date of last dental exam _____ Significant findings _____

8. Date of last eye examination _____ Significant findings _____

9. Does your child wear glasses or contacts: Yes (please specify, _____) No

Thank you for providing this information to help us provide the best care we can for your child. This information will be shared with school personnel only when deemed necessary for your child's educational experience.

DATE _____

Signature _____