SWALLOW SCHOOL 2018-2019 ANNUAL STUDENT HEALTH UPDATE

Student Name: _____Date of Birth: _____ Grade_____
Student's Address:_____

- If the student lives at multiple houses during the week, please indicate additional address and schedule:
- Additional Address:_____
- Schedule:_____

Mother's Name: _____ Daytime Phone Number_____
Father's Name: _____ Daytime Phone Number_____
Emergency Contact: _____Daytime Phone Number_____

Health Care Provider's Name: _____ Phone Number _____
Hospital Preference:_____

Does your child have any special health concerns? Yes_____ No_____

Asthma* ☐ Diabetes* ☐ Seizure Disorder* ☐ Other* ☐ _____

If other, please explain: _____

Does your child have any severe allergies? Yes_____ No_____

	List allergic item(s):	Describe Reaction:	Date of last reaction:
☐ Food(s)*			
☐ Insect(s)*			
☐ Latex*			
☐ Medication(s)			
☐ Other			

*** An Allergy Action Plan or Individual Health Plan must be filled out every year for the above health concerns and allergies. Forms may be obtained from the school office or downloaded from the school website.**

Is your child currently taking medication? Yes__ No__ **Will medication be taken at school?** Yes*__ No__

Name of Medication(s)	Reason for taking

*** If yes, a Medication Administration Authorization form must be completed and turned into the nurse**

Please provide other information or past medical history you think would be important for us to know: ____

_____

_____

Parent/guardian signature:_____ Date:_____