

ST. MARIA GORETTI SCHOOL
ANNUAL STUDENT HEALTH SURVEY
 2009-2010

For us to maintain complete medical records on our returning students **PLEASE FILL OUT THIS FORM AND RETURN IT TO THE SCHOOL NURSE ON BOOK DAY**

STUDENT NAME _____ SEX _____ GRADE _____
 PARENT'S NAME(S) _____
 DOCTOR'S NAME _____ DOCTOR'S PHONE # _____
 DATE OF LAST PHYSICAL EXAM _____

With your permission we would like to know of any changes in your child's health status. Has your child developed any new health conditions such as ADD, vision problems, new glasses, contacts, broken bones, a physical handicap, any recent surgeries, injuries or other pre-existing or new illnesses?

YES NO

Explain: _____

To better help your child in the event of an emergency or illness, please list all of the medications your child is taking at home or in school and the reasons for taking them.

Medication	Dose	Frequency	Reason
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

All prescription medications and non-prescription medications must be in their original containers. There must be a Permission for Prescription Medication or Permission for Non-prescription Medication form filled out and signed at the time the medication is brought to the nurse's office.

Please update any NEW immunizations providing month, day and year (M/D/Y). (See the Family Policy Guide for immunizations required for each grade. **Please send an updated copy of the immunization record from your doctor.**

DPT / / PPD(TB) / / Polio / / MMR / / Gardasil / / Menactra / /
M D Y M D Y M D Y M D Y M D Y M D Y

CHICKEN POX / / Other / / Other / / Other / /
M D Y M D Y M D Y M D Y

If your child does have or has had any of the following, please check and provide the date of diagnosis.

ALLERGIES: YES NO ALLERGIC TO: _____

ASTHMA _____	INFECTIOUS HEPATITIS _____
CHICKEN POX _____	MONONUCLEOSIS _____
DIABETES _____	RHEUMATIC FEVER _____
EPILEPSY _____	PNEUMONIA _____
HAY FEVER _____	EAR TUBES _____
ULCERS _____	EAR INFECTIONS _____
SCARLET FEVER _____	SCOLIOSIS _____ TREATMENT _____
MIGRAINES _____	SEIZURES _____
NOSEBLEEDS _____	OTHER _____

NOTICE

I give my permission for my child's medical information forms to be shared with his/her teachers on a NEED TO KNOW basis. I understand that the nurse needs my child's medical information to assist my child as needed during the school year. I understand that only that medical information which is beneficial to my child's health in the classroom will be shared confidentially with his/her teachers.

PARENT OR GUARDIAN SIGNATURE _____ DATE _____