2023-2024

SILVER CREEK CENTRAL SCHOOL DISTRICT
ANNUAL STUDENT HEALTH HISTORY UPDATE

NAME	AGE	GRADE	BIRTHDATE	GENDER: ☐ M ☐ F

UPK and K: Please turn in immunization records and a physical for your child within the last year to the Health Office. Physicals/Health Appraisals are mandated for Universal Prekindergarten and Kindergarten students.

Grades 1-12: Please turn in any immunizations and any new physicals received since last school year to the Health Office. Physicals/Health Appraisals are mandated for grades 1, 3, 5, 7, 9, 11, new enterers, and athletes.

***Physicals will be completed by the school doctor if proof of a recent physical is not on file in the Health Office.**

List recent illness, injury, surgery or new diagnosis since last school year:

CHRONIC CONDITIONS

	YES	NO	DESCRIBE	TREATMENT
DIABETES: type 1 or type 2				
HEART PROBLEMS				
MIGRAINE HEADACHE				
SEIZURES (list type)				
VISION PROBLEM				
HEARING PROBLEM				
CONCUSSION(S) IN LAST 12 MONTHS			If yes: how many	
OTHER				

ALLERGIES

ANAPHYLAXIS – A SUDDEN SEVERE WHOLE BODY ALLERGIC REACTION REQUIRING EMERGENCY CARE

STUDENT IS ALLERGIC TO THIS FOOD:	THIS CAUSES ANAPHYLAXIS? YES NO
Describe the reaction if this food is eaten and what is done to manage it:	
STUDENT IS ALLERGIC TO THIS MEDICATION:	THIS CAUSES ANAPHYLAXIS? YES NO
Describe the reaction and how it is managed:	
STUDENT IS ALLERGIC TO THIS INSECT:	THIS CAUSES ANAPHYLAXIS? YES NO
Describe the reaction and what is done to manage it:	
OTHER ALLERGY:	THIS CAUSES ANAPHYLAXIS? YES NO
Describe the reaction and what is done to manage it:	

ASTHMA

HAS YOUR STUDENT BEEN DIAGNOSED WITH ASTHMA? YES NO
WHAT TRIGGERS YOUR CHILD'S ASTHMA? ACTIVITY ALLERGIES COLDS/VIRUS OTHER
WHAT SYMPTOMS DOES YOUR CHILD HAVE?
WHAT TREATMENT RELIEVES YOUR CHILD'S ASTHMA?
DOES YOUR CHILD USE AN INHALER? YES NO DOES YOUR CHILD USE A NEBULIZER? YES NO

PLEASE COMPLETE REVERSE SIDE

SOCIAL AND EMOTIONAL WELLNESS

**** All diagnoses must be supported with a physician statement.***

HAS STUDENT BEEN DIAGNOSED WITH ATTENTION DEFICIT DISORDER (ADD) OR ADHD? PLEASE EXPLAIN.
DOES STUDENT HAVE A SOCIAL OR EMOTIONAL HEALTH CONCERN? PLEASE EXPLAIN.
IN THE PAST YEAR HAS STUDENT BEEN SEEN OR IS CURRENTLY SEEING A PROFESSIONAL TO ADDRESS SOCIAL OR EMOTIONAL CONCERNS?

MEDICATIONS – INCLUDE ALL ORAL, INHALED, INJECTABLE, AND TOPICAL/PATCHES

NAME OF MEDICATION	REASON FOR TAKING	DOSE	TIME(S) TAKEN	*AT SCHOOL
				YES NO
				YES NO
				YES NO
				YES NO

***PLEASE NOTE:* New York State Law requires a signed Health Care Provider Consent Form for *each* school year for all medications, treatments, and special diets in school including inhalers. Health Care Provider Consent is also required for students to carry their own inhaler in school.**

Please list any additional concerns: _____

_____

What type of Medical Coverage does your child have?

Company: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

- If deemed necessary my child will be sent for emergency treatment at parental/guardian's expense.
- As a parent/guardian, I authorize medical personnel to render necessary medical treatment to my child.
- I give consent to release this information to Silver Creek Central School District personnel to promote the health and safety of my child, thus enhancing his/her ability to learn.
- I will notify the Health Office of any medical changes throughout the school year.
- I give permission to share the above information with appropriate staff on a "need to know" basis.

PARENT/GUARDIAN SIGNATURE	DATE