ECHO CHARTER SCHOOL STUDENT HEALTH INFORMATION/UPDATE

Studer	ıt	Date of Birth	Grade
Male_	Female		
Modice	al History / Health Concerns:		
Medica	ADD/ADHD: YesNo		
	The state of the s	Peaction	
	Bee sting allergy: YesNo Type of F Medication allergy: YesNo Medicat	ion and type of Reaction	
	Medication affergy. 1 es140 Wedican		
	Other allergy: YesNo To what and ty	pe of Reaction	
	Asthma or other breathing problem: Yes No		
	a. Has your child ever been diagnosed		Yes No
	b. Is an inhaler needed at school? Yes No		
	Bladder or bowel problem (explain):		
	Diabetes: Type 1 Type 2 Managed by:	Diet only Oral Meds	Insulin injections Insulin Pumn
	Diabetes: Type I Type Z Wanaged by.	Diet only Oral wieds	
	Eating Disorder (explain):		
	Headaches:		
	Heart Problems (explain):		Date of last seizure:
	Seizures: Type (explain)	ms (describe):	Date of fast scizure.
	Activity Restrictions (describe):	No. If you plants over	aloin:
	Any recent surgeries or nospitalizations: Yes	No II yes, please exp	Jani
	Student has other health concerns: Yes No		
	Student has other hearth concerns. Tes1\ou		
	explain any other condition or health conce		
Does y	our child have a health problem that could	result in an emergency? I	f yes, explain
			1 1 20 M
IS YOUR CHILD CURRENTLY USING ANY MEDICATION (including inhalers)? Yes No			
If so, p	lease list name and for what purpose		
	20		
If your	child has medications (including inhalers) that	they will need during school,	please have a signed doctor's order and
parent permission form completed. Forms may be obtained at the school. All medications must come to school in the original			
contain	er. It will be kept in a locked closet unless a wr	itten agreement between the	school and parents is in place.
		¥*	
Vision: No glasses Glasses/contacts prescribed Wears glasses/contacts all the time			
9	Wears glasses in classroom only Glasses	lost/broken has glasses	but does not wear them
	,		
Hearing: No hearing problems frequent ear infections (3/year) has ear tubes Hearing lossR_L Hearing aid(s) R L has aids but does not wear			
3	rearing aid(s)i\L has aids but does not	wcar	
This in	formation on this form may be shared with	school staff and emergence	cy personnel if appropriate.
Family	Doctor	Family Dentist	
Date of	Doctor	Date of last dental exam	1
Parent	/Guardian Signature	Ds	ate
1 mi ont	- Carrier Nagarrena V		

Thank you for completing this important information. Please contact the school nurse if there is a change to ANY of the above information.

Form revised 7/08