Athol-Royalston Regional School District 2014-2015 Grade ____

Annual Health Survey - For School Nurse Use Only Teacher _____

LIFE THREATENING ALLERGIES: Please indicate if your child has an allergy to any of the following. If yes, please provide official documentation by your child's physician. Written prescriptions from your child's doctor are required for **ANY** medication that is given during the school year.

Bee Stings _____ Peanuts _____ Nuts _____ Food _____ Latex _____ Other _____

Describe your child's reaction: _____
Describe how the reaction was last treated: _____

OTHER ALLERGIES: Please list
Medications: _____
Environmental: _____
Describe reactions: _____

Date of last Physical Exam: _____ **Date of last Dental Exam:** _____

Primary Care Physician Name: _____ Phone # _____
Physician Specialist Name: _____ Phone # _____
Medical Insurance: _____ Policy # _____
Dentist Name: _____ Phone # _____
Dental Insurance: _____ Policy # _____

ILLNESS/CHRONIC CONDITIONS: Indicate if your child has experienced any of the following below.

Asthma _____	Anxiety _____	Attention Deficit _____
Concussion _____	Depression _____	Diabetes _____
Fainting _____	Heart Condition _____	Seizures _____
Injuries over summer _____	Migraines _____	Mobility concerns _____
Hospitalizations _____	Scoliosis _____	Toileting concerns _____
Surgeries _____	IEP _____	Dietary concerns _____
504 _____	Physical limitations _____	Other _____

Please explain: _____

VISION: Glasses : Yes ___ No ___ Worn constantly: Yes ___ No ___ Contact lenses: Yes ___ No ___
Special seating needed: Yes ___ No ___
HEARING: Frequent earaches: Yes ___ No ___ Ear tubes: Yes ___ No ___ Hearing aids: Yes ___ No ____
Special seating needed: Yes ___ No ____
SPORTS: Do you know any reason your child should not participate in sports/PE? Yes ___ No ___
Please explain: _____
**A physical exam is required annually for middle and high school level sports.*

MEDICATIONS: Please list prescribed and over the counter medications your child takes. Please provide name and dose of medication. * *A reminder that this information is kept confidential.*

1. _____
2. _____
3. _____
4. _____

**Medication orders from a physician are required before any medication can be administered at school.*

Please complete the following items with asterisks.

I, *_____, Parent/guardian of *_____,
(Parent/guardian name) (Student name)

Do give permission for health information to be shared with necessary school staff.
Do give permission for communication and Fax use between my child's physician and the School Nurse to exchange necessary information.
Do grant the right to obtain emergency medical treatment for my child.
Do give permission for ambulance transport to the nearest hospital. Payment for any and all medical treatment is the financial responsibility of the parent/guardian.

*Parent/Guardian Signature: _____ Date: _____

This information is valid for one year from the date of your signature.