NEW KENT COUNTY PUBLIC SCHOOLS
YEARLY HEALTH HISTORY UPDATE

Name of School:_____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth:_____ Sex: _____

Student's Address:_____ City:_____ State:_____ Zip: _____

Name of Parent or Legal Guardian 1:_____ Phone:___ - ___ - _____ Work or Cell:___ - ___ - _____

Name of Parent or Legal Guardian 2:_____ Phone:___ - ___ - _____ Work or Cell:___ - ___ - _____

Emergency Contact:_____ Phone:___ - ___ - _____ Work or Cell:___ - ___ - _____

Condition	Yes	Medications/ Comments	Condition	Yes	Medications/ Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
ADD/ADHD			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic Fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Contact your student's school nurse if you would like to discuss any confidential health information.

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: _____None _____FAMIS Plus (Medicaid) _____FAMIS _____Private/Commercial/Employer sponsored

If you are interested in free or low cost health insurance go to this link: www.famis.org

Parent/Guardian for the safety of your student, please provide any emergency medication and medical supplies needed to care for your student prior to their arrival at school (Benadryl, Epi-pen, Inhaler, Other). A Doctor order and written parent/guardian permission is required for medication to be administered at school.

I,_____, **authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form.** *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school.*** *When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian:_____Date:____/____/_____

Signature of person completing this form:_____Date:____/____/_____