East Greenwich Township School District
HEALTH HISTORY UPDATE 2023-2024

Student's Name: _____ DOB: _____ Grade: _____

Child's Physician:_____ Phone: _____

In case of an emergency, I understand that my child will be taken to the nearest hospital. I grant permission for my son/daughter to receive emergency hospital treatment if necessary. Medications such as Benadryl, Anbesol, cough drops, hydrocortisone cream and Neosporin may be administered on standing orders by the school physician. Acetaminophen and Ibuprofen may be administered per label instructions and standing orders from our school physician after speaking with the parents when it is warranted.
I give my permission to share this medical information with any school personnel who have contact and responsibility for the safety and well being of my child. I give permission for the school nurse to speak to my child's doctors on my child's behalf. By typing my name, I give permission to share this medical information with any school personnel who have contact and responsibility for the safety and wellbeing of my child. I give permission for the school nurse to speak to my child's doctor on my child's behalf.

_____	_____	_____
Child's Health Provider	***Office Phone Number***	***Fax Number***
_____	_____	_____
Parent's Name Printed	***Parent's Signature***	***Date***

_____ **NO changes or updates** in health condition(s) since last school year. ***(If checked, please also sign the back page.)***

Please check the health conditions your child has: ____ **My child has NO health conditions** ***(Please do not forget to sign the back page.)***

____ ADHD	____ Concussion/TBI	____ Kidney Problems
____ Allergies (see below)	____ Congenital Disorders	____ Migraine Headaches
____ Anxiety	____ Dental Problems	____ Muscular Problems
____ Arthritis	____ Diabetes	____ Nosebleeds
____ Asthma (see below)	____ Down Syndrome	____ Neuromuscular Disorders
____ Autism Spectrum Disorders	____ Gastric Reflux	____ Orthopedic (Bone) Disorders
____ Bleeding Problems	____ Genetic Disorder	____ Seizures (see below)
____ Bowel /Bladder Problems	____ Hearing Problems	____ Throat Infections
____ Celiac Disease	____ Heart Conditions	____ Other_____

Provide additional information below for any conditions checked above

ALLERGIES

FOOD _____ REACTION _____

****Does your child need to sit at a PEANUT/TREE NUT free table? Y ___ N___ *Do they react if they come in contact with (not ingest) the allergen Y ___ N___***

MEDICATION _____ REACTION _____

ENVIRONMENTAL _____ REACTION _____

INSECT _____ REACTION _____

LATEX _____ REACTION _____

*Is emergency Epinephrine prescribed? Y ___ N___ **(If yes, please have physician complete the FARE Emergency Care Plan form found on the school website)**

ASTHMA

Medication needed at school: No Yes If yes, when : Daily_____ Before Gym/Recess _____ With Symptoms _____

Date of last episode? _____ **(Please have your physician complete the Asthma Action Plan which can be found on the school website if meds are needed in school)**.

HEART CONDITIONS

TYPE OF PROBLEM: _____ ACTIVITY LIMITATIONS? Y ___ N___ DATE OF LAST EXAM: _____

SEIZURES

Check type: Convulsive __ Non-Convulsive __ Absence __

Date of most recent seizure: _____ Medication/dosage: _____

(Please have a Seizure Action Plan completed by physician which can be found on the school website)

PLEASE PROVIDE ADDITIONAL INFORMATION FOR ANY HEALTH ISSUES BELOW:

_____

_____

Does your child have any eye problems (crossed eyes, reddened or watery eyes)? _____

Does your child wear glasses/contacts: Y ___ N___ Date of Last Eye Exam: _____

Has your child had tubes inserted into his/her ears to alleviate fluid and ear infections? Y ___ N___ DATE: _____

Are they currently in place? Y ___ N___ RIGHT EAR _____ LEFT EAR _____

Does your child wear any corrective devices? Y ___ N___

Hearing Aids: R ear___ L ear___ Both ___ Dental Appliance/Braces ___ Back Brace___ Leg Brace___ Orthotics___

Specify when to be worn: _____

Is your child on a diet restriction or special diet? Y ___ N___ If so, please explain: _____

Is your child taking any medication at home on a daily basis? Y ___ N___ If so, please complete information below

Medication: _____ Dosage: _____ Reason: _____
Medication: _____ Dosage: _____ Reason: _____

Has your child had any serious illness in the past year? (Including COVID-19, pneumonia, etc.) Y ___ N___
If yes, explain: _____ Date: _____

Has your child been hospitalized or had surgery in the past year? Y ___ N___

If yes, explain: _____ Date: _____

Has your child had any serious injury or broken bones in the past year? Y ___ N___

If yes, explain: _____ Date:_____

Has your child fainted in the past year? Y ___ N___

If yes, explain: _____Date: _____

Has your child complained of chest pain in the past year? Y ___ N___

If yes, explain:_____ Date: _____

Has your child been advised not to participate in an activity or sport in the past year? Y ___ N___

If yes, explain: _____ Date: _____

Has your child faced any emotional experiences this past year? (Divorce, separation, family illness/death, relocation, remarriage, new baby)

Y ___ N___ If so, please explain: _____

Parent Signature ***Date***