Bangor Christian Schools
Annual Health Update Form
(Required each year for each student)
2017-2018

In order to keep the individual school health record up to date, we are requesting that you complete this form and return it by *August 15th*. If you have more than one child you may make copies of this form or we can send you additional copies if needed.

Child's Name: _____ Grade Entering: _____

Contact Parent's Name: _____ Daytime Phone: _____

DOB:_____ Age: _____

Date of most recent visit to:

Family doctor: ___/___/___ Name of Doctor:_____ Phone #: _____

Eye Doctor: ___/___/___ Name of Eye Doctor: _____ New Glasses? _____

Dentist: ___/___/___ Name of Dentist: _____

Does your child have any current medical problems (such as asthma, diabetes, seizures, heart condition, ADHD, etc)? Yes _____ No _____ If yes, please list: _____

Does your child take any medications regularly? Yes _____ No _____

Please list all medications:_____

Does your child have a special diet for health reasons? Yes _____ No _____ If yes, type of diet:

_____

☐ ***Check here if no changes in health status from last year, and sign below.***

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During the summer or past year, has your child had any of the following?

Illness, accident or operation? If yes, please list and ***include dates***:_____

Immunizations or boosters? Yes _____ No _____ If yes, ***NAME OF VACCINE & DATE GIVEN:*** _____

If yes, also send or fax (262-9528) a photocopy of the shot(s) with doctor's stamp or signature. When your child receives any immunizations during the school year, please send in the name of the immunization and date given.

List date if your child received the H1N1 vaccine ***in the past year***: _____

ALLERGIES? (Including bee stings, peanut, tree nuts, etc.) _____

If you listed allergies, does your child need an Epi-Pen, (epinephrine injection, or Benadryl?)

Yes _____ No _____ ***IF YES, NAME OF MEDICATION***: _____

If your child has an epi-pen, (epinephrine injection) does he/she administer it? Yes _____ No _____

If your child takes Benadryl, what is the dose? _____

Has your child ever had a concussion? Yes_____, if yes date _____ No____

Does your child have an inhaler? Yes ____ No _____ Does he/she administer it? Yes _____ No _____

It may be necessary to share health information with your child's teacher (verbally, in written form, or by e-mail) to ensure their safety and welfare. Please give your consent to the sharing of pertinent health information by signing below (if you have questions or concerns about this, please do not hesitate to call: 207-947-7356. ***Please sign and return this form***.

Parent's Signature: _____

If your child has asthma, please fill in the information on the back of this sheet!

SCHOOL ASTHMA RECORD

1. What causes your child's asthma symptoms?

_____ Allergies

_____ Cold Weather

_____ Upper respiratory illness

_____ Exercise

_____ Other: _____

2. How often does your child have an acute episode?_____

3. Does your child use medication? Yes _____ No _____

If yes, give directions and time taken: _____

_____

Please check type of medication used:

_____ Albuterol or Ventolin inhaler _____ Theophylline

_____ Intal inhaler _____ Vanceril inhaler

_____ Other: _____

4. Does your child routinely use a peak flow meter? Yes _____ No _____

If you think your child will need asthma medication during school hours in this school year, please check here: _____

We will send you a medication permission slip that you and your child's physician will need to complete. Please note that <u>all prescription medications</u> on school grounds need to carry an original prescription label and kept in the main office of the building in which your child attends.

5 . Does your child understand asthma and what he or she should do to manage it?

Yes _____No _____

If your child is experiencing an asthma episode and you feel they should <u>not</u> participate in gym or recess during cold weather, please notify the school.

Thank you for your help with keeping us informed of your child's medical history.

Lois Cole, R.N.

School Nurse