



ST. ROBERT BELLARMINE SCHOOL Annual Student Health Update

Name _____ Grade _____

1. Your help is needed to update your child's health status and assist school personnel to identify potential classroom emergencies and health issues which may affect your child's learning. Please complete this form and return to school by the first day of school.

Check any health concerns below which pertain to your child:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies, specify _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Injuries	<input type="checkbox"/> Vision
<input type="checkbox"/> Mental/emotional	<input type="checkbox"/> Recent surgery	<input type="checkbox"/> Seizures	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Other, specify _____			

If you checked any of the above, please specify symptoms, treatment, restrictions and needed adjustments.

My child has no health needs requiring special consideration at school.

2. List all medications your child is currently taking (include name, dose, time, and reason):

3. Date of last physical exam _____ dental exam _____

4. Date of last eye exam by eye care provider _____ glasses yes no

5. List health care providers/phone numbers, include specialists: _____

Parent/Guardian Signature _____ Date _____

Phone Number (Home) _____ (Work) _____ (Cell #) _____

My signature grants permission for St. Robert Bellarmine staff or a specified volunteer to review my child's health information. It is the parent's responsibility to notify the school office if changes occur. The medication authorization must be completed before any medications can be given at school.