

Pine Valley Central School District

ANNUAL HEALTH INFORMATION UPDATE SCHOOL Year _____

TO BE COMPLETED BY PARENT / GUARDIAN AND RETURNED TO PVCS SCHOOL NURSE

Student's Name _____ Grade _____

Please complete the following checklist and give details below (attach any additional pertinent information).

Does the student currently or had in the past year, any of the following conditions?

	YES	NO		YES	NO
Allergies (seasonal, food, environmental, medication, insect)			Headaches/Migraines		
Behavioral issues			Heart Condition or treatment		
Contagious illness/infectious illness			Hepatitis		
Anemia (include Sickle Cell)			High Blood Pressure]		
Arthritis (rheumatoid conditions, scleroderma)			Learning Difficulties (ADD/ADHD/other)		
Asthma (give details below)			Mononucleosis or other viral illness		
Back / Neck Injury			Orthopedic (skeletal injury, treatment, surgery)		
Bladder / Kidney Disease			Psychiatric or psychological issues & treatment		
Bleeding / Clotting Disorder			1. anxiety, depression		
Cancer			2. psychosis		
Chickenpox			Surgery		
Convulsions or Seizures			Speech Evaluation and Therapy		
Diabetes or Hypoglycemia [low blood sugar]			Vision Impairment or correction		
Head Injury (Concussion/ loss of consciousness)			Weight related issues (eating disorder, obesity)		
Hearing Loss/Correction & Evaluation			Other		

Please give details and dates to all of the above marked **YES**. _____

➤ Is the student currently under any kind of **medical care or treatment**? _____ YES _____ NO
 Explain _____

➤ Is the student taking any **medication** on a regular basis (prescription or non-prescription)? _____ YES _____ NO
 List the medication, dose, times and reasons for taking. _____

Contact the school nurse to make arrangements for any meds to be given in school.

Has the student received the following immunizations or boosters since last reporting to school?
 Please provide dates below & **follow-up with written documentation from your physician.**

Meningitis: _____ Tdap [Tetanus, Diphtheria, Acellular Pertussis] _____ Gardasil Series _____

Date of last Physical exam _____ Physician _____ Phone _____

Date of last Dental exam _____ Dentist _____ Phone _____

Describe any **modifications or restrictions** that are needed to accommodate your child's health or safety. _____

Is there any other information that you would like the nurse to know? _____

Parent/Guardian Signature: _____

Your signature authorizes nurse to share health information with school staff on a "need to know" basis.

When you have a concern or new information related to your child's health or safety, please call or email the Elementary school nurses at (716) 988-3291 ext 6 Mrs. Hills {phills@pval.org} or Mrs. Pollock {jpollock@pval.org} or call or email the High school nurse Mrs. Kenney at (716) 988-3276 {jkenney@pval.org}.