Manchester-Shortsville CSD, Red Jacket Schools

ES Nurse: Sarah Huber, RN
Phone: (585) 289-9650
Fax (585) 289-2114
Email: Sarah.Huber@redjacket.org

MS/HS Nurse: Tammy LaBarr, RN
Phone: (585) 289-3968
Fax: (585) 289-2112
Email: Tammy.Labarr@redjacket.org

STUDENT HEALTH HISTORY UPDATE - TO BE COMPLETED BY PARENT

Child's Name: _____ DOB: _____ Age: _____ Grade: _____
Physician: _____ Phone #: _____
Dentist: _____ Phone #: _____

1. Has your child ever been a patient in a hospital (other than a few days after birth)?
Yes - If yes, please explain why and when below. No - If no, go to question #2

My child was in the hospital because:	**Date**

2. Is your child taking any prescription, inhalers, and/or over-the-counter medications?
Yes - if yes, please list the child's medicines below. No - If no, go to question #3

Name of Medication(s)	**Please list dosage and time(s)**

3. Does your child have any **allergic reaction** from any of the following?

- Outside or indoor allergies,(for example grass, pollen, cats...) **please list below**
- Food allergies (for example peanuts, milk, wheat...) **please list below**
- Insect or animal allergies (for example bees, wasps, cats...) **please list below**
- Medication or immunizations? **please list below**
- Does your child have an **Epi-Pen?** If **Yes**, please bring to school with a doctor's order.

My child is allergic to:	**What happens when your child has a reaction?**

(Please complete reverse and sign)

3. Has your child had any of the following medical problems or injuries?

Check (✔) all that apply and describe your child's problem on the lines provided below.

Has an ongoing medical condition; if so please describe below:	
Surgery (date, if had surgery)	
Head injury or concussion	
Ear infections (how often has them, ear tubes, etc.)	
Hearing problems (has trouble sometimes, wears hearing aids)	
Nose problems (sinus infections, nose bleeds)	
Eye problems (blurry vision, wears glasses, lazy eye)	
Should wear glasses or contacts to: (circle one) see far away read	
Mouth or throat problems (history of strep throat, swallowing problems)	
Speech/articulation concerns (stutters, is difficult to understand)	
Constipation (problems having bowel movements)	
Problems urinating (bed wetting, pain when urinating)	
Back problems (scoliosis, back pain)	
Muscle and bone problems (weak muscles, pain in joints)	
Skin problems (acne, flaking skin, rashes, hives)	
Seizures (shaking fits or convulsions)	
ADD/ADHD (problems paying attention, sitting still)	
Breathing problems (cough, asthma)	
Heart problems (fast or irregular heartbeat, murmur, birth defect)	
Feelings or emotions (depression, anxiety, fears)	
Bipolar Disorder	
OCD/ODD	
Autism	
Other:	

Did you check any problems above? Tell us more here: _____

_____

_____

I authorize _____ or _____to be called in case of illness or injury to pick up my child if I am unable to be reached. During a medical emergency, I understand my child may be transported via ambulance to the nearest medical facility at the parent/guardian expense. I authorize Manchester-Shortsville School District's Registered Professional Nurse caring for my child to contact my child's health care provider if necessary. All attempts to reach parent will be initiated.

I understand it is my responsibility to keep all contact information current with school.

Signature of Parent/Guardian: _____ Date: _____

Print Parent/Guardian Name: _____

Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse and submit a form in a sealed envelope marked "Attn: School Nurse"