Killingly Public Schools Health Department

St James School

Yearly Update Health Information Form

Name: Last _____ First _____ Middle Initial_____
Date of Birth: _____ Male _____ Female _____ Grade entering: _____
Address: _____
Father/Guardian Name: _____ Home# _____ Cell# _____
Mother/Guardian Name: _____ Home# _____ Cell# _____
Email Address: _____
With whom does the student live? _____
Is this a change since last year? _____ Yes _____ No
Siblings and ages: _____

Please check if your child had a specialized plan for medical or educational management last year:
_____ IEP _____ 504 _____ IHP Explain: _____

Does your child have health insurance? _____ Yes _____ No
Health Insurance Carrier: _____ Husky _____ BC/CS _____ Health Net _____ Other
Policy # _____

Date of Last Physical Exam: _____ Name of Family Doctor: _____
Date of Last Dental Exam: _____ Name of Family Dentist: _____
Immunizations up to date: _____ Yes _____ No
List any new immunizations since last year:
_____

Has your child had any accidents or operations since last year? _____ Yes _____ No
Explain if yes: _____
_____

Please identify any SEVERE ALLERGIES AND REACTIONS: **If YES, ALLERGY ACTION PLAN is needed

Allergies	Type	Reaction Description
☐ Bee Sting		
☐ Food		
☐ Medication		
☐ Environment		
☐ Other		

Please state name of medications that should be administered at school in case of SEVERE ALLERGIC REACTION: _____
_____

1/2009

**** Please turn page over and fill out the back side of form****

Does your child have Asthma? _____ Yes _____ No ** If YES, ASTHMA ACTION PLAN is needed.
Is this a new diagnosis since last year? _____ Yes _____ No
Please check type of trigger for Asthma: _____ Illness _____ Allergy _____ Exercise _____ Cold Air
Please describe your child's Asthma symptoms: _____
Names of medications (dosage and frequency) given at home: _____

Has your child had or been diagnosed with any of the following: Please check if yes.

_____ ADD or ADHD
_____ Bronchitis
_____ Cancer
_____ Chicken Pox
_____ Constipation (chronic)
_____ Diabetes
_____ Ear infections (chronic)
_____ Ear tubes
_____ Eczema
_____ Heart Disease
_____ Incontinence (bladder or bowel)
_____ Lyme Disease
_____ Other: _____

_____ Measles
_____ Migraine Headaches
_____ MRSA
_____ Mumps
_____ Pneumonia
_____ Polio
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Seizure
_____ Stomach aches (chronic)
_____ Step Throat
_____ Tuberculosis or contact

Does your child wear glasses? _____ Yes _____ No
Glasses should be worn for: _____ Reading _____ Distance _____ Full time wear

Does your child have any physical limitations or restrictions on activity? _____ Yes _____ No
If yes, please explain:
_____

Does your child take any medication on a daily basis: _____ Yes _____ No
If yes, please describe:
Name of medication _____ Dosage _____ Reason _____
_____

Please list, with details, any other concerns regarding your child that you feel school personnel should be aware of:

_____
_____

_____ _____
Parent / Guardian's Signature Date

1/2009