Grand Island Central School District
Annual Health Update

Dear Parent/Guardian:

Please complete both sides of this form and return to your school's Health Office the following day. This information is confidential and will only be shared with appropriate school personnel. I hereby give my permission for this information to be shared with appropriate school personnel.

Signature Parent/Guardian: ______________________________ **Date:** ____________

Please notify the school of any changes that may occur during the school year.

Student's Last Name: ____________________ First Name: ____________________

Address: ______________________________ Phone: ____________

Grade: __________ Teacher: ____________________ Date of Birth: ____________

Physician's Name: ______________________________ **Phone:** ____________

Dentist's Name: ______________________________ **Phone:** ____________

*** * IMPORTANT * ***

New York State law requires that all new entrants (whether Pre-K or K), 2nd, 4th, 7th, & 10th graders and all students entering a school district for the first time have a physical examination completed no more than 12 months prior to the entry of the first day of school

Please check one of the following:

☐ I give permission for my child to receive a physical at school by the school physician

☐ My child had a physical within the past 12 months on __________, or has an appointment scheduled for a physical on ____________. If this option is checked,

The completed physical form and copy of immunizations must be returned to school by OCTOBER 1st

Forms are available in your school's Health Office or may be downloaded from the Grand Island Central School District website at www.k12.ginet.org

Signature Parent/Guardian ______________________________ Date ____________

PLEASE UPDATE SINCE THE LAST SCHOOL YEAR, INCLUDING OVER THE SUMMER:

Has child had: (Give dates where appropriate)

Chickenpox __________ Mononucleosis __________ Bronchitis __________

Hepatitis __________ Rheumatic Fever __________ Pneumonia __________

Scarlet Fever __________

Has child had: (Indicate specific body part, i.e. right/left, date, medical diagnosis or Dr. where appropriate)

Head Injury __________ Broken Bones __________ Surgery __________

Loss of Consciousness __________ Bowel/ Bladder Problem __________ Serious Injury __________

(Continue on the back of this page)

Has child contracted frequent: (more than 4-5 per year)

Headaches ______ Stomachaches ______ Earaches/ Infections ______

Sore Throat/ Strep Infections ______ Skin Rashes/ Eczema ______

Please update with your child's information: (Give explanations where necessary)

Asthma: ______

Medication: ______ Dr: ______

Allergies (*Food, Medication, Environmental, Seasonal*) ______

Medication: ______ Dr: ______

Diabetes: ______

Medication: ______ Dr: ______

Seizure Disorder: (*Type*) ______

Medication: ______ Dr: ______

Heart Murmur: ______

Does your child have a:

Vision Problem? ☐ Yes ☐ No ______ Wear Glasses? ☐ Yes ☐ No

Date of last appointment: ______ Dr: ______

Hearing Problem? ☐ Yes ☐ No ______ Tubes in ears? ☐ Yes ☐ No

Date of last appointment: ______ Dr: ______

List any other NEW medical problems: ______

Does your child regularly take any medication at home? ☐ Yes ☐ No **If yes, please describe:**

Medication: ______ Dosage: ______ Time: ______

Prescribed by Dr. ______ For: ______

Medication: ______ Dosage: ______ Time: ______

Prescribed by Dr. ______ For: ______

Will your child be taking any medication during school hours? ☐ Yes ☐ No

If yes, please be sure to have the appropriate authorization form for administration of medication in school filled out by your child's healthcare provider and signed by you. Any medication to be given during school hours must be brought to school by a parent. This form may be obtained from your School Nurse or downloaded from the district's website at www.k12.ginet.org

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