

**SOUTH PORTLAND SCHOOL DEPARTMENT
SCHOOL HEALTH DEPARTMENT
ANNUAL HEALTH UPDATE**

Name of Student _____ School _____ Grade _____

Dear Parent or Guardian:

Please complete **both sides** of this form, sign and return it to school **immediately**. The medical and health information is kept confidential and will help school personnel to meet the needs of your child while in school. A confidential list is prepared and may be viewed by the staff. It is not shared outside of school. SPSHS student health and immunization records are kept in the nurses' office.

If your child has a health issue you wish to discuss with the school nurse in confidence and to not be shared on the list, please call 767-3266 x208. The nurse is at S.P.H.S. throughout the school day, each day.

1. Does your child have any health problems the school should be aware of? Yes No (if yes, please explain)

2. Has your child been hospitalized, injured or treated by a physician since the last school year? (over the summer) Yes No (If yes, please explain)

3. Does your child have any activity restrictions? Yes No (If yes, please explain)

4. Does your child take pills, injections, inhaler or have medical treatments on a part-time or regular basis? Yes No (If yes, please explain)

Reminder-ANY medication taken at school must have written parental permission-see the student handbook- call school for appropriate form. Medication may be administered by medical or non-licensed personnel. Students may carry their inhalers, insulin, Epi-Pens with parent/nurse/physician permission.

5. Does your child have any **SERIOUS** allergy or reaction (i.e. breathing problems, swelling, hives) to:
Foods Yes No (If yes, please list)

Medicines Yes No (If yes, please list)

Environment Yes No (If yes, please list)

Bee Stings Yes No (if yes-please explain below)

Does your child carry an Epi-Pen? Yes no

If "yes" to any of the above please explain-include symptoms and procedure to follow in case of reaction

6. **For 9th grade students:** My child has had chicken pox yes no (circle one)

My child has had the chicken pox vaccine (varicella) date _____

(parent must provide proof of disease or vaccination from health care provider or sign a waiver in order for your child to attend school if no proof of having vaccine or having the disease-contact nurse if questions)

Any additional information or concerns:

Please sign below if this information may be shared in confidence with appropriate So. Portland School Department staff. Your signature also acknowledges that medication which you authorize, may be administered by either medical or non-licensed personnel.

Parent Signature _____ Date _____