USD 265 Goddard Public Schools
Pride. Growth. Excellence.

# USD 265 Goddard Public Schools
## 2016-2017 Annual Health Information Update
**(This information must be updated annually by parent/guardian)**

_____ _____ Wesley Med Ctr Via Christi-St Francis
**Student Name** **Grade/School** Via Christi-St Joseph Via Christi-St Teresa
***Nearest Hospital of Choice (circle one)***

My child is routinely in the care of (*circle all that apply)* Physician Dentist Eye Doctor

Please circle Yes or No for each question and provide additional information where necessary

| | | |
|---|---|---|
| 1. Is your child on **ANY routine medications** (at home or school)? If yes, list:<br>**Name of Medication/Dose** **Circle one** **Reason for med**<br>1. _____ Home / School _____<br>2. _____ Home / School _____<br>3. _____ Home / School _____<br>4. _____ Home / School _____<br>5. _____ Home / School _____<br>***Form GD-67** REQUEST TO ADMINISTER MEDICATIONS AT SCHOOL , must be completed with information and signatures for EACH medication to be administered at school. This form must be completed annually and is available at www.goddardusd.com* | YES | NO |
| **Has your child been diagnosed by a physician with :** *(note any meds above)* | | |
| 2. Circle **ANY** that apply: | Yes | No |
| ADD/ADHD Asthma Mental Health/ Behavior Disorder | | |
| Diabetes Seizure Disorder | | |
| 3. Other Medical Condition: | Yes | No |
| **Does your child:** | | |
| 4. Wear **Glasses or Contacts** *(please circle)* | Yes | No |
| Reading Only or All the time *(please circle)* | | |
| Any other vision problems?/Vision Therapy? *(please list)* | Yes | No |
| | | |
| 5. Have **Hearing difficulties:** | Yes | No |
| If so, do they wear a hearing aid? | Yes | No |
| | | |
| 6. Have **Allergies** to any **Medications** | Yes | No |
| List all meds/type of reaction: | | |
| | | |
| 7. Have **FOOD ALLERGY documented by a physician:** | Yes | No |
| ( ) Benadryl ( ) Epi Pen ( ) Care Plan | | |
| List all foods/type of reaction: | | |
| **If any changes are to be made to the regular school lunch, **Form 19D** will be required with a physician signature. This form is on the district website (www.goddardusd.com), through Nutrition Services or from your school nurse.* | | |
| 8. Does your child know to stay away from the foods he/she should not eat? | Yes | No |
| 9. Does your child have **ANY other health concerns** that we should be aware of? | Yes | No |
| List: | | |

Your signature is required for this Information to be shared with the Goddard staff members who have contact with your student. Please contact the school nurse if you need insurance resources.

_____ _____
Parent/Guardian Signature Date

Rev: 3/2016