

USD 265 Goddard Public Schools
2017-2018 Annual Health Information Update
 (This information must be updated annually by parent/guardian)

Student Name

Grade/School

Wesley Med Center Via Christi-St Francis
 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: <table border="1"> <thead> <tr> <th>Name of Medication/Dose</th> <th>Circle one</th> <th>Reason for med</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>Home / School</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>Home / School</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>Home / School</td> <td>_____</td> </tr> <tr> <td>4. _____</td> <td>Home / School</td> <td>_____</td> </tr> <tr> <td>5. _____</td> <td>Home / School</td> <td>_____</td> </tr> </tbody> </table> <i>*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</i>			Name of Medication/Dose	Circle one	Reason for med	1. _____	Home / School	_____	2. _____	Home / School	_____	3. _____	Home / School	_____	4. _____	Home / School	_____	5. _____	Home / School	_____	YES	NO
Name of Medication/Dose	Circle one	Reason for med																				
1. _____	Home / School	_____																				
2. _____	Home / School	_____																				
3. _____	Home / School	_____																				
4. _____	Home / School	_____																				
5. _____	Home / School	_____																				
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:																						
<i>*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.</i>																						
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