

**USD 265 Goddard Public Schools**  
**2018-2019 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  
 Physician First and Last Name: \_\_\_\_\_

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

	YES	NO																		
1. Is your child on <b>ANY routine medications</b> (at home or school)? If yes, list: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%; text-align: left;"><u>Name of Medication/Dose</u></th> <th style="width: 15%; text-align: center;"><u>Circle one</u></th> <th style="width: 40%; text-align: left;"><u>Reason for med</u></th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td style="text-align: center;">Home / School</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td style="text-align: center;">Home / School</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td style="text-align: center;">Home / School</td> <td>_____</td> </tr> <tr> <td>4. _____</td> <td style="text-align: center;">Home / School</td> <td>_____</td> </tr> <tr> <td>5. _____</td> <td style="text-align: center;">Home / School</td> <td>_____</td> </tr> </tbody> </table> <p><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 <a href="http://www.goddardusd.com">www.goddardusd.com</a></i></p>	<u>Name of Medication/Dose</u>	<u>Circle one</u>	<u>Reason for med</u>	1. _____	Home / School	_____	2. _____	Home / School	_____	3. _____	Home / School	_____	4. _____	Home / School	_____	5. _____	Home / School	_____		
<u>Name of Medication/Dose</u>	<u>Circle one</u>	<u>Reason for med</u>																		
1. _____	Home / School	_____																		
2. _____	Home / School	_____																		
3. _____	Home / School	_____																		
4. _____	Home / School	_____																		
5. _____	Home / School	_____																		
<b>Has your child been diagnosed by a physician with :</b> (note any meds above)																				
2. Circle <b>ANY</b> that apply:	Yes	No																		
ADD/ADHD                      Asthma                      Mental Health/ Behavior Disorder																				
Diabetes                              Seizure Disorder																				
3. Other Medical Condition:	Yes	No																		
<b>Does your child:</b>																				
4. Wear <b>Glasses or Contacts</b> (please circle)	Yes	No																		
Reading Only    or    All the time (please circle)																				
Any other vision problems?/Vision Therapy? (please list)	Yes	No																		
_____																				
5. Have <b>Hearing difficulties:</b>	Yes	No																		
If so, do they wear a hearing aid?	Yes	No																		
_____																				
6. Have <b>Allergies</b> to any <b>Medications</b>	Yes	No																		
List all meds/type of reaction:																				
_____																				
7. Have <b>FOOD ALLERGY documented by a physician:</b>	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, <b>Form 19D</b> will be required with a physician signature. This form is on the district website (<a href="http://www.goddardusd.com">www.goddardusd.com</a>), 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 <b>ANY other health concerns</b> 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