

## USD 265 Goddard Public Schools 2021-2022 Annual Health Information Update

(This information must be updated annually by parent/guardian)

			Wesley Med Center Via Christi-St Francis				
Student Name Grad		chool \	Via Christi-St Joseph Via Cl			nristi-St Teresa	
Nearest Hospital of Choice (c						circle one	?)
My chi	ld is routinely in the care of (circle all that app	alv) Phys	ician	Dentist	Fve (	Doctor	
Physician First and Last Name:							
Please circle Yes or No for each question and provide additional information where necessary							
Is your child on <b>ANY routine medications</b> (at home or school)? If yes, list:							
Name of Medication/Dose Circle one Reason for med YES							NO
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		Iome / School	_				
	·	lome / School					
	*Form GD-67 REQUEST TO ADMINISTER MEDIC	•		must he comp	leted		
	with information and signatures for EACH medication to be administered at school. This						
	form must be completed annually and is availa				11113		
Has your child been diagnosed by a physician with : (note any meds above)							
	Circle <b>ANY</b> that apply:	with . (note	uny med	is above)		Yes	No
۷.		Montalli	oolth /	Dobovior Di	cordor	163	INO
	ADD/ADHD Asthma		eaith/	Behavior Di	sorder		
	Diabetes Seizure Disord	der					
3. Other Medical Condition:					Yes	No	
Does your child:							
4.	Wear Glasses or Contacts (ple	ease circle)				Yes	No
	Reading Only or All the time (please circle)						
	Any other vision problems?/Vision Therapy	y? (please lis	t)			Yes	No
5.	Have <b>Hearing difficulties</b> :					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:						
	, n						
7.	Have FOOD ALLERGY documented by a pl	hvsician:				Yes	No
	() Benadryl () Epi Pen () Care Plan	,				1	
	List all foods/type of reaction:						
	*If any changes are to be made to the regular s	school lunch. <b>F</b>	orm 19E	<b>)</b> will be requir	ed with		
	a physician signature. This form is on the district website (www.goddardusd.com), through						
	Nutrition Services or from your school nurse.	,	3	,,	3		
8.	Does your child know to stay away from th	e foods he/s	he shou	uld not eat?		Yes	No
9.	Does your child have ANY other health con				of?	Yes	No
	List:						
						1	1
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			Dat	e		