THIS FORM MUST BE RETURNED TO SCHOOL

GETTYSBURG AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

HEALTH SURVEY

It is necessary to update each student's record yearly. Please fill out this form **completely** and return it to your child's teacher ***immediately***.

Name of Student	Date of Birth	Grade	Teacher
_____	_____	_____	_____

Student's Doctor:_____ Phone:_____

Student's Dentist:_____ Phone:_____

Serious accidents/injuries/operations? Please explain:_____
(Type and Year)

Has your Child had a head injury/ concussion this past summer: Yes/ No

Allergies? Yes____ No____ Explain:_____
(List allergies and treatment for each)

Asthma? Yes_____ No____ Explain:_____
(List medications and "triggers")

Check physical conditions and explain treatment/ medications:

_____Hearing:_____Ear Tubes? Past:____Present:____

_____Vision:_____Wears glasses?_____Contacts?___

_____Heart or Lungs:_____

_____Epilepsy/Seizure Disorder:_____

_____Attention Deficit Disorder/Hyperactivity: Medication taken_____

_____Any other health problems _____ Medication taken _____

May we share this information with teachers? ____ Yes or ____ No

Is your child limited in physical activities? _____ Explain:_____
(A doctor's note will be required if student cannot participate in phys-ed.)

Please cross out any medications that may NOT be given to your child by the School Nurse

Tylenol, Ibuprofen, Midol	Tums/ Rolaids	Wound Antiseptic, Skin Cleanser	Throat Lozenges/Cepacol, Sucrets Chloraseptic Spray
Blistex/Vaseline	Oral Anesthetic/ Orabase, Anbesol	Eye wash/ contact Solution	Antibiotic Ointment
Topical Analgesics: Sting/Pain/Itch Reliever (Aloe, Hydrocortisone 1%, Sting Kill, Calamine), Sunscreen			

Date Completed:_____ Signature of Parent/Guardian:_____

Updated: 5/12, 1/13, 9/13, 5/15, 5/17