

Health Update Form

Lee County Schools

Complete Annually, One (1) per student

Student Last Name (Please Print)	Student First Name (Please Print)	Student's Physician & Phone #	Grade
Anaphylaxis is a serious allergic reaction which may cause shortness of breath, throat tightness, swelling of the tongue, difficulty breathing, hives, swelling, etc. Anaphylaxis requires immediate medical treatment, including an injection of epinephrine and an emergency room visit. Most common causes of anaphylaxis are Foods, Stinging insects, Medications, and Latex.			
Does your child experience <u>Anaphylaxis</u> for any <u>food, stinging insect, medication, latex</u> etc. ☐ YES ☐ NO If Yes, for what? _____ Does your child have an EPI PEN? ☐ YES ☐ NO			
Is your child being treated for <u>Asthma</u> ? ☐ YES ☐ NO If yes, will your student have an inhaler at school? ☐ YES ☐ NO			
Is your child being treated for <u>Diabetes</u> ? ☐ YES ☐ NO Does your child manage symptoms/calculations/injections of insulin on his/her own? ☐ YES ☐ NO			
Is your child being treated for <u>Epilepsy or Seizures</u> ? ☐ YES ☐ NO If YES, what kind of seizures? _____			
Has your child been diagnosed or being treated by a physician for any of the following?			
☐ ADHD	☐ ADD	☐ Seasonal Allergies	☐ Physical Disabilities
☐ High Blood Pressure	☐ Anxiety/Depression	☐ Panic Attacks	☐ Medication Allergies
☐ Cancer	☐ Speech Difficulties	☐ Nose bleeds	☐ Headaches/Migraines
☐ Heart Disease	☐ Learning Disabilities	☐ Developmental Delays	☐ Nervousness
☐ Kidney Problems	☐ Asperger's	☐ Autism	☐ Psychological Issues
☐ Blood disorders	☐ Stomach issues	☐ Skin Issues	☐ Other
Briefly explain any marked: _____			
Will your child be taking any prescription or over the counter medications while at school? ☐ YES ☐ NO If yes, what medication/s? _____			
A "Permission Form for Prescribed or Over-the-Counter Medication", (Form 09.2231 AP.21) is available at the school office. This form must be completed for any medication a student will need to take during school hours. This form must be completed by the student's doctor and/or parent.			
Is your child currently on any routine medication? ☐ Yes ☐ No If yes, please list below:			
Medication _____	Dosage _____		
Medication _____	Dosage _____		
Medication _____	Dosage _____		
Does your child have any difficulty with vision? ☐ YES ☐ NO UNSURE Does your child wear glasses on a daily basis? ☐ YES ☐ NO REFUSES TO WEAR			
Does your child have any difficulty with hearing? ☐ YES ☐ NO UNSURE Does your child wear hearing aids? ☐ YES ☐ NO REFUSES TO WEAR			
Does your child have any other health problems which would need attention during school? ☐ YES ☐ NO Please Explain: _____			
In case of an emergency, accident, or serious illness of the above named child, I request the school to contact me. If school personnel are unable to contact me, I hereby authorize them to call the people whom I have placed on my child's emergency contact list. If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.			
Parent/Guardian's Name: (PLEASE PRINT) _____ Date: _____			
Parent/Guardian's Signature: _____			