Joplin Public Schools Health Record Update
For School Year: _______________

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following form and return it to the school nurse. This is required annually.

Student: ____ DOB: _________ Grade: _____ Sex: M / F

(Last) (First) (MI)

Medical History, check all that apply: Please explain conditions marked in space below chart.

	Asthma		**Respiratory Impairment**		**ADHD/ADD**
	Food Allergy		**Kidney/Urinary Disorder**		**Anxiety Disorder**
	Diabetes		**Scoliosis**		**Bipolar Disorder**
	Low Blood Sugar		**Skin Disorder**		**Depression**
	Seizure/Neurological Disorder		**Bone/Joint Disorder**		**Hearing Impairment/hearing aids**
	Heart Disorder		**Stomach Disorder**		**Glasses/Contacts**
	Drug Allergy		**Migraines**		**Vision Disorder**
	Other Ållergy		**Blood Disorder**		**Other**

Note: Physician documentation is an essential responsibility for parents/guardians to provide for all significant diagnoses such as: Asthma, Food Allergy, Seizure, Diabetes, and others. A separate emergency action plan must be prepared for these significant diagnoses.

Please explain any conditions checked above: ____

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List any Surgeries: ____

Please explain any allergic reaction requiring emergency intervention: ________________________________

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Do you believe your child has a physical or mental impairment that substantially limits a major life activity in the school environment? Yes / No. If yes, please explain the condition and how it substantially limits your child:

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Please list any medications your child takes at home: ____

Note: If a student is to receive medication at school, a separate form will need to be completed.

While medical information is confidential, I understand the school nurse and other school staff may at times deem it necessary to share a student's information, including district health update forms as supplied by the parent, with other school personnel, including but not limited to, teachers, administrators, transportation and cafeteria staff. By signing this form you authorize emergency treatment in a life threatening situation including the use of epinephrine in case of a severe allergic reaction. (If this is not acceptable please provide written notification to the contrary.)

Parent/Guardian Signature:____Date: __________

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(For nursing notation only below this line. Staff to list date and initials when making a notation>)

Counselor Referral: _______________ Action Plan Given (specify type) _______________ Notation on Infinite Campus: __________________

Action Plan Received (specify type): _________________ Other: ____

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