

## Ventura Community School Annual Student Health Update

Student Name: \_\_\_\_\_ Gender: M F  
 Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_ Building: \_\_\_\_\_  
 Parent/Guardian Name(s): \_\_\_\_\_

Family Doctor:	Date Last Seen:
Eye Doctor:	Date Last Seen:
Wears Glasses?	Wears Contacts?
Dentist:	Date Last Seen:
Specialty Doctor:	Date Last Seen:
Specialty Doctor:	Date Last Seen:

Medication Taken Regularly	Dosage	How Often	Condition Medication is Taken For

Allergies (food, environmental, latex, etc.)	What Type of Reaction

**Current Illness:** List any illness, injury or surgeries occurring since last school year, including the date they occurred: \_\_\_\_\_

**Chronic Illness or Conditions that may affect school performance:** List any health conditions such as asthma, migraines, seizures, diabetes, hearing problems, ADHD, behavioral, etc.: \_\_\_\_\_

Immunizations Received in the <i>Last Year</i> (Month/Year)		
Hepatitis B #1:	Hepatitis B #2:	Hepatitis B #3:
Tdap:	Chicken Pox:	Varicella:
Gardasil (HPV):	Menactra (MCV4):	
Other (list name of immunization and date received):		

**Please turn over and complete page 2**

### INSURANCE

Does student have:

- Private Insurance (List Name) \_\_\_\_\_
- Medicaid
- HAWKI
- No Insurance
- Other (List Name) \_\_\_\_\_

### PERMISSIONS

In case your child is ill or injured at school or during a school event out-of-town, and we think he/she needs medical attention, do you grant school personnel permission to do so?

Yes \_\_\_\_\_ No \_\_\_\_\_

If student's health care provider is not available, may we send him/her to another local provider?

Yes \_\_\_\_\_ No \_\_\_\_\_

I give my child permission to receive Tylenol/Acetaminophen for complaints of discomfort at school from the school nurse and trained school personnel at their discretion for this school year.

Yes \_\_\_\_\_ No \_\_\_\_\_

Over-the-Counter Medication: I give permission for the use of topical antibiotic ointment (Bacitracin), contact solution, Benadryl, or Caladryl as needed by the discretion of the health office and trained school personnel. Yes \_\_\_\_\_ No \_\_\_\_\_

### MEDICATION POLICY

I understand that my child can receive prescription medications at school through School Health Services. I understand that the medication must be in the original container with all the information current to what the child receives. **I understand that a Medication Permission form must be signed and accompany the medication. This form can be obtained from the Health Services office in the school building your child attends.**

**NOTICE: The school does NOT assume financial responsibility for medical/dental bills incurred as a result of illness or school accidents. If needed, there is student accident insurance available for your child. The application can be picked up in a building office.**

**NOTICE: Student's health information is shared with appropriate staff in accordance with the District's policy/procedure and applicable laws of confidentiality. Information is shared on a "need to know" basis with school personnel who supervise students.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_