EASTCONN
Where Learning Comes to Life

Student Health Update Form

Student Name: _____ Date of Birth: _____ Grade: _____ Gender: Male / Female

Mailing Address: _____

Emergency Contact Information:

For IMMEDIATE dismissal DURING SCHOOL HOURS, the following adults are available and permitted to pick up the student:

Name: _____ Phone: _____Email: _____

Name: _____ Phone: _____Email: _____

For ROUTINE, NON-EMERGENCY the school should contact the following adult using : ____ Text ____ Call ____ Email

Name: _____ Phone: _____ Email: _____

Health Information:

List any ALLERGIES to food, insects, latex, medication, etc: _____

If yes, date of last reaction: _____ Please describe the reaction: _____

Does your child require an Epi Pen? Yes / No *Medication Authorization Form required*

Please Note: Students with undiagnosed life-threatening allergies may require emergency treatment with epinephrine. Parents may opt-out of epinephrine for life-threatening allergic reactions by providing a written statement to the School Nurse.

In the past 3 years has he/she experienced any of the following symptoms?

Any health concerns	Yes / No	Dental braces, caps, or bridges	Yes / No
Any problems with vision	Yes / No	Concussion	Yes / No
Uses contacts or glasses	Yes / No	Fainting or blacking out	Yes / No
Any problems hearing	Yes / No	Chest pain	Yes / No
Any problems with speech	Yes / No	Heart problems	Yes / No
Hospitalization or Emergency Room visit	Yes / No	High blood pressure	Yes / No
Any broken bones or dislocations	Yes / No	Bleeding more than expected	Yes / No
Any muscle or joint injuries	Yes / No	Problems breathing or coughing	Yes / No
Any neck or back injuries	Yes / No	Smoking or any other tobacco use	Yes / No
Problems running	Yes / No	Asthma treatment	Yes / No
"Mono" in the past year	Yes / No	Known asthma triggers	Yes / No
Has only 1 kidney or testicle	Yes / No	Seizure treatment	Yes / No
Excessive weight gain or loss	Yes / No	Diabetes	Yes / No
Any relative have a sudden unexplained death (less than 50 years old)	Yes / No	ADHD/ADD	Yes / No
Any dietary restrictions (include parent preference and physician ordered)	Yes / No	Anxiety	Yes / No
Has student travelled outside of US for more than 1 month OR is student immunosuppressed OR has the student had close contact to someone with infectious Tuberculosis (TB)?			Yes / No
Is the child FULLY vaccinated against COVID-19? (more than 2 weeks after second dose)			Yes / No

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Please explain all "Yes" answers, including date or student's age as appropriate:

_____

_____

Health Care Provider: _____ Phone Number: _____

Dental Care Provider: _____ Phone Number: _____

Psychiatrist: _____Phone Number: _____

Please list ALL current medications: *Medication Authorization Form required for ANY medication to be administered in school*

Medication	Dose	Time	Reason for taking medication	Will dose be needed during school hours?

Attach additional sheets as needed.

Does the student currently have active health insurance? Yes / No Company: _____

If the student does NOT have health insurance, please visit www.accesshealthct.com or www.huskyhealth.com for information on low-cost or free coverage. More information available upon request.

Are there any other health concerns you feel the school should be aware of?

_____

_____

_____

The above information is true to the best of my knowledge and may be shared with EASTCONN personnel and school bus drivers on a need-to-know basis to provide for student well-being and safety at school. I understand any changes or updates to this information should be shared with school personnel as soon as possible.

Parent/Guardian Signature _____Date _____

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