Dear Parents,

The purpose of this form is to ascertain the health status of your child. The form is utilized to provide quick access to a guardian or designated persons in case of emergency, or illness. As a means of knowing your child more effectively, we ask that you fill the card out entirely and provide the necessary phone numbers of persons to speak in your behalf if we are unable to contact you. Please contact the school health care provider with any questions or concerns.
YORK COUNTY SCHOOL DIVISION
HEALTH UPDATE FORM

Please complete in ink

Name ____________________________ Sex _____ Grade _____ Teacher __________________________

Address ____________________________ Sex _____ Grade _____ Teacher __________________________

Parent/Guardian

Mother __________________________________________ Home# __________ Work# __________ Cell# __________

E-mail address ____________________________ Home# __________ Work# __________ Cell# __________

Father __________________________________________ Home# __________ Work# __________ Cell# __________

E-mail address ____________________________ Home# __________ Work# __________ Cell# __________

Student lives with ____________________________ Home# __________ Work# __________ Cell# __________

Physician’s Name ____________________________ Number __________________________

Dentist’s Name ____________________________ Number __________________________

Orthodontist’s Name ____________________________ Number __________________________

If parents/guardians are not available, in case of emergency, accident or illness, call: Please keep numbers updated

Name ____________________________ Home# __________ Work# __________ Cell# __________

Name ____________________________ Home# __________ Work# __________ Cell# __________

Does your child have any medical conditions that will require special care? If so, indicate below in detail:

YES   NO

Allergies: State what kind: Environmental, food, insect and what treatment ____________________________

Asthma: Physician’s name/number/medication ____________________________

ADD or ADHD ____________________________

Cardiovascular: Condition and Cardiologist’s name/number ____________________________

Diabetes: Physician’s Name and Number ____________________________

Hearing Deficit (wears hearing device? Yes/No) ____________________________

Juvenile Arthritis ____________________________

Migraines: Physician’s name/number and Medication ____________________________

Physical Limitations: ____________________________

Scoliosis: Physician’s name/number ____________________________

Sickle Cell Anemia: Physician’s name/number ____________________________

Seizures: Neurologist’s name/number Medication ____________________________

Urinary Tract Problem: Condition and Urologist’s name/number ____________________________

Vision Correction- glasses/contacts- circle one ____________________________

Wheelchair bound ____________________________

Other ____________________________

List any childhood diseases ____________________________

Medication taken regularly ____________________________

Is your child covered by health insurance? Yes ________ No ________

Signature of Parent/Guardian ____________________________ Date ____________________________

Name ___________________________________________________________________ Sex _____ Grade ________ Teacher __________________________________________

Last __________________________________________ First __________________________________________ Middle __________________________________________

Address _____________________________________________________________________________ Birthdate ____________________ Bus Number ________

Parent/Guardian

Mother __________________________________________ Home# __________ Work# __________ Cell# __________

E-mail address ____________________________ Home# __________ Work# __________ Cell# __________

Father __________________________________________ Home# __________ Work# __________ Cell# __________

E-mail address ____________________________ Home# __________ Work# __________ Cell# __________

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Dentist’s Name ____________________________ Number __________________________

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Last __________________________________________ First __________________________________________ Middle __________________________________________

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Father __________________________________________ Home# __________ Work# __________ Cell# __________

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