VISTA UNIFIED SCHOOL DISTRICT
STUDENT HEALTH UPDATE

Student_____ Today's Date_____
Date of Birth_____

1) What is your student's handicapping condition or underlying medical condition?

2) Has your child had any operations, hospitalizations, or major illnesses in the past year? If so explain and provide dates.

3) Does your child have any allergies? (food, medication, bee stings or environmental).

4) MEDICAL HISTORY
Place an X on the appropriate line or describe health problem.

Anemia____
Medication_____
Behavioral Problems____
Medication_____
Bleeding Disorders____
Describe_____
_____
Dental Problems____
Prosthesis____
Last Exam_____
Diabetes____
Diet_____
Insulin____ Amount_____
Other Meds_____
_____
Blood Testing____
Urine Testing____
Ear Infections____
Frequency_____
Last Infection_____
PE Tubes- Rt____ Lt____
Hearing Impaired____ RT____ LT____
Hearing Aids ____ RT____ LT____
Both____
Last Audiogram_____
Heart____
Describe Condition_____
_____
_____

Impaired Mobility____
Braces____ Walker____
Wheelchair____
Other_____
Menstrual Cramps____
Mild____ Mod____ Severe____
Medication_____
Respiratory____
Oxygen____ Liters/Min.____
Asthma____
Medication_____
Other_____
_____
Seizures____ Type_____
Duration_____
Date of Last Seizure_____
Medication_____
Describe action taken during seizure_____
_____
_____
Self Abusive____
Precautions_____
_____
Shunt____ Date of Last Exam_____
Skin Sun Sensitivities____ Precautions_____
_____
Urinary ____ Toilets self ____ Needs Assistance____
Wears Diapers____ Other_____
Visually Impaired ____ Glasses____ Contacts____
Date of Last Exam_____

Questionnaire continues on the back of this page

5) Medications that your child receives at home:

NAME OF MEDICATION	DOSAGE	TIMES GIVEN	REASON FOR MEDICATION

6) List all medications you would like given at school:

NAME OF MEDICATION	DOSAGE	TIMES TO BE GIVEN

7) Name of Physician_____

Date of Last Exam_____

8) Please list any services or benefits your child receives from other community agencies? (CCS, Regional Center, Therapies)

9) I would like a conference with the school nurse regarding my child's health or health services.

YES____ NO____

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE