GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL

HEALTH INFORMATION

NAME:_____ DOB:_____ ID#:_____ YOG:_____

TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED WITH THE PACKET OF FORMS

Date of last physical exam:_____

Medical Provider's Name:_____

Please provide an up-to-date, most recent physical.

Dental Provider's Name:_____

The purpose of the following list is to identify issues, which may have an impact on your son/daughter's school experience. All information will be kept in the nurse's office and confidentiality will be maintained. Health information will only be shared with appropriate faculty/staff with your permission on a need to know basis.

I AGREE THAT THE INFORMATION PROVIDED ON THIS FORM MAY BE SHARED ON A NEED TO KNOW BASIS ONLY WITH MY SON/DAUGHTER'S TEACHERS AND OTHER APPROPRIATE FACULTY/STAFF. € YES € NO

Y	N		Y	N	
€	€	**ADD/ADHD**	€	€	**Hearing / Hearing Aid**
€	€	**Allergy to Food**	€	€	**Heart: Murmurs / Surgery / Pacemaker / Defibrillator**
€	€	**Allergy to Insects**	€	€	**Immune**
€	€	**Allergy to Medication**	€	€	**Inhaler _____**
€	€	**Allergy Other _____**	€	€	**Medication**
€	€	**Anxiety / Social / Emotional**	€	€	**Neurological**
€	€	**Asthma**	€	€	**Neuromuscular**
€	€	**Autism Spectrum Disorder**	€	€	**Physical Limitations / Adaptive Device**
€	€	**Benadryl**	€	€	**Psychiatric / Mental Health Disorder**
€	€	**Bone / Joint / Muscle**	€	€	**Recent Illness / Accident / Surgery**
€	€	**Cancer**	€	€	**Scoliosis**
€	€	**Concussion**	€	€	**Seizure Disorder**
€	€	**Developmental**	€	€	**Skin**
€	€	**Diabetes**	€	€	**Urinary / Kidney**
€	€	**Dietary Restrictions**	€	€	**Vision: Glasses / Contacts / Other**
€	€	**Ear / Throat**	€	€	**Other**
€	€	**Endocrine**	€	€	**IEP**
€	€	**Epi Pen**	€	€	**504 Plan**
€	€	**Gastrointestinal**			
€	€	**Gynecological**			

IF YOU ANSWERED *YES* TO ANY OF THE ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION.

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PLEASE ADD ANY INFORMATION THAT YOU WOULD LIKE TO BRING TO THE ATTENTION OF THE SCHOOL NURSE REGARDING YOUR SON/DAUGHTER'S PHYSICAL OR EMOTIONAL WELL-BEING.

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I GIVE PERMISSION FOR MY CHILD'S MEDICAL INFORMATION TO BE RELEASED TO HIS/HER PRIMARY CARE PHYSICIAN AS NEEDED. _____YES _____NO

Parent/Guardian Signature:_____Date:_____