Shutesbury Elementary School

www.shutesburyschool.org
23 West Pelham Road, Shutesbury, MA 01072
Phone: (413) 259-1212 Fax: (413) 259-1531

Anne Magill, Principal email: magilla@shutesburyschool.org

Annual Health Update 2025-2026

Student Name:_____ Date of Birth:_____ Grade:_____

Physician Name:_____Date of Last Physical:_____

Dentist Name:_____Date of Last Exam:_____

Dear Caregiver(s):

In order to keep your student's health record up to date and provide better health services, we ask that you complete the following annual health history and return it to the school nurse. Please be sure to include all medications (with dosage) that your student takes at home. Include a copy of your student's most recent physical and immunization records (required for Pre-K, Kindergarten, and 4th grade), if not previously provided.

Circle "YES" or "NO"

1. Has your student been diagnosed with any of the following?

ADD/ADHD	YES	NO
Autism Spectrum Dis.	YES	NO
Asthma	YES	NO
Diabetes	YES	NO
Eczema	YES	NO
Epilepsy/Seizures	YES	NO
Headaches/Migraines	YES	NO
Heart Condition	YES	NO

Psychiatric Disorder (i.e. Depression, Bipolar disorder, anxiety) YES NO

2. Does your student take any medications? YES NO
   (if yes, please list_____
   (if yes, will your student need to take medication during school hours?_____
   All medications need to be hand delivered to the school nurse along with a physician order and signed caregiver consent. ***Please NEVER send medication to school with your student.***

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3. Does your student have a life threatening allergy requiring the use of an EpiPen?
   YES NO
   If yes, what is the allergy/allergies?_____
   If yes, has your student ever had an anaphylaxis reaction? _____

4. Does your student wear glasses or contact lenses? YES NO
   If yes, what is the necessity for glasses _____

5. Does your student see a hearing specialist? YES NO
   Does your child get chronic ear infections? YES NO
   Does your child have tubes in their ears? YES NO

6. Does your student have any food sensitivities? YES NO
   What foods?_____
   Gluten sensitivity/intolerance? YES NO
   Environmental allergies? YES NO

7. Does your student have any present physical limitations that may require program modifications or restrictions? YES NO
   If yes, pleases explain_____

8. Have there been any significant changes (i.e. accidents, illness, death, loss, separation/divorce) or change of living arrangements over the summer of 2025?
   YES NO

_____

If emergency treatment is required for your student and the caregivers cannot be reached immediately, the school nurse will exercise their own judgment in calling the physician indicated and/or transport the child to a hospital emergency room via ambulance

Please add any other concerns or comments that you would like to bring to the attention of the school nurse:

All information above is confidential and will only be shared with essential staff members IF it benefits your child (i.e. allergies, glasses/contacts, safety concerns)

Signature of Caregiver_____Date:_____