Mayfield Central Schools

Health Record Update

Student Name: _____ **Grade:** _____

Physician's Name: _____ **Phone number:** _____

Please list any health concern you have for your child. This information will be reviewed by the Health Office. Please include medications they are taking, either in school or at home, or any surgery or serious injury that has occurred over the past year. This will ensure continuity of care from your home to the school setting.

Allergies diagnosed by a physician

_____

_____ **Date diagnosed:** _____

Care required for allergies, if any: _____

_____

* Please note any inhaler will need a doctor prescription and parental consent to be used in school. These may be obtained through the Health Office.

Diabetes: ☐ Please check this box if your child has been diagnosed with diabetes. *If yes, please arrange a care schedule with the Health Office.*

Seizure disorder: ☐ Please check this box if your child has been diagnosed with a seizure disorder. *If yes, please arrange a care schedule with the Health Office.*

Contacts: ☐ ***Glasses:*** ☐ *Please check the appropriate box if your child wears contacts or glasses.*

Medications taken on a regular basis (*include frequency*): _____

_____

*Please list medication and reason for use. Medication given in school requires physician prescription and parent consent, which may be obtained through the Health Office. This includes over the counter medication, for example, Tylenol, Advil, cold medications, etc.

Please list any other health concerns: _____

Please feel free to call Health Office with any concern regarding your child

Elementary School Health Office: 661-8254
High School Health Office: 661-8211

It is the parents'/guardians' responsibility to notify the bus driver of any health concerns.

For the safety and wellness of my child, I give the Health Office permission to share this information with staff (on a need-to-know basis only)

Parent's signature: _____ **Date:** _____