

**MARION COUNTY HEALTH DEPARTMENT
ANNUAL PUPIL HEALTH UPDATE**

DATE _____

2011-2012

SCHOOL _____

Dear Parent/Guardian: In order to update your child's health records please complete the following and return to school. Thank you.

Child's Name: _____ Birth Date _____ Grade: _____
(Last) (First) (MI)

Address: _____ Phone: Home _____ Cell _____

Parent/Guardian's Name: _____

Emergency Contact During the Day: Name: _____ Phone: _____

Physician/Usual Treatment Center: _____ Phone: _____

Does your child have any allergies? Yes No

If yes, please list allergies: _____

Please check any conditions your child has:

Asthma

Eye Problems

Nose Bleeds

Bee Sting Reaction

Hearing Loss

Rheumatic Fever

Cancer

Heart Condition

Scoliosis

Cerebral Palsy

Hemophilia

Seizures

Cystic Fibrosis

High Blood Pressure

Sickle Cell

Diabetes

Muscle Problems

Urinary Tract Infection

Please describe any conditions checked: _____

Please list any routine medicine your child is taking: _____

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