HEALTH UPDATE FORM

Health Center – School Year 2025-2026

Student Name: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Please Answer All Questions or Mark N/A

# **Are there any NEW medical issues since last Fall?** [ ]  Yes [ ]  No

If yes, please describe: Click or tap here to enter text.

# **Does your child have a known history of seizures?** If yes, please describe a typical seizure.

Click or tap here to enter text.

In the event of a life-threatening emergency, medical treatment will be provided to all students following Maryland School for the Blind medical directives including the use of oxygen for respiratory distress, epinephrine for anaphylactic shock, and diastat for convulsive seizures.

# **What medications does your child take?** Please list meds taken at home and school. Include dosage, frequency, and times.

Medications taken at school: Click or tap here to enter text.

Medications taken at home only: Click or tap here to enter text.

# **Please list current allergies. Are there any new allergies since last year?**

Medication Allergies: Click or tap here to enter text.

Food Allergies: Click or tap here to enter text.

Environmental Allergies: Click or tap here to enter text.

[ ]  No Allergy to Medicine, Food or Environment

[ ]  This information will be up to date as of the date this form is signed. I will keep the Health Center informed of any changes in the health of my child to the best of my abilities.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

Printed Name of Parent/Guardian: Click or tap here to enter text.

PB/LB/cic:4/26/25