

**IMMACULATE CONCEPTION SCHOOL  
HEALTH INFORMATION CHANGE  
2009-10 SCHOOL YEAR**

**Please fill in current information that the school should know.**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

1. Does your student take any medications regularly? Yes\_\_\_ No\_\_\_  
If yes, name medication \_\_\_\_\_
  
2. Is your student
  - a. Allergic to bee stings? Don't know\_\_\_ Yes\_\_\_ No\_\_\_  
If Yes, state treatment required \_\_\_\_\_
  - b. Allergic to grass/pollens requiring medication/treatment? Yes\_\_\_ No\_\_\_  
If Yes, state treatment required \_\_\_\_\_
  - c. Allergic to medicine? Yes\_\_\_ No\_\_\_  
If Yes, name the medicine \_\_\_\_\_
  - d. Allergic to any foods? Yes\_\_\_ No\_\_\_  
If Yes, name the food \_\_\_\_\_
  - e. State any other allergy \_\_\_\_\_
  
3. Does he/she wear glasses/contacts? Yes No  
Are glasses for distance? \_\_\_\_\_ reading? \_\_\_\_\_ all the time? \_\_\_\_\_
  
4. Is your student colorblind? (failed color vision test)? Yes\_\_\_ No\_\_\_
  
5. Does he/she have a hearing problem? Yes\_\_\_ No\_\_\_  
Left ear? \_\_\_\_\_ Right ear? \_\_\_\_\_ Both ears? \_\_\_\_\_
  
6. Does your student need to sit near the front? Yes\_\_\_ No\_\_\_  
If Yes, give reason \_\_\_\_\_
  
7. Does your student have asthma? Yes\_\_\_ No\_\_\_  
If Yes, does he/she use an inhaler? Yes\_\_\_ No\_\_\_  
State name of inhaler \_\_\_\_\_  
How frequently is the inhaler used?  
More than once a week? \_\_\_\_\_  
2 -3 times a month? \_\_\_\_\_  
1 - 6 times a year? \_\_\_\_\_
  
8. Name any other health condition that the school should be aware of \_\_\_\_\_
  
9. Is any of this health information new in the last 12 month? Yes\_\_\_ No\_\_\_

All school records are kept strictly confidential and are only shared by the appropriate staff.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date