OSMOND COMMUNITY SCHOOL 2008-2009
DEPARTMENT OF HEALTH SERVICES

Child's Name:_____ Grade:_____

Dear Parent:
Please answer the following questions and return to your child's teacher or the Principal's office. This information will be recorded on their permanent record card.

1. Has your child had any serious illness or injury the last year that would limit his/her activity?
   YES_____ NO_____ If yes, please explain:
   _____

2. Is he/she afflicted with any of the following? Please circle.

   Diabetes Asthma Allergies Hayfever Epilepsy Orthopedic Health

   Please list allergies, type of reactions, and treatment measures:
   _____

3. Does he/she take any regular medications? YES _____ NO _____

   If yes, please explain:_____

4. If any other new health problems exist, please explain:_____
   _____

5. Did your child have any corrections during this summer?

   Eyes: Fitted with glasses _____ Optometrist:_____
   Ears: Reason_____ Doctor:_____
   Teeth: Work done_____ Dentist:_____

6. List any vaccinations or immunizations received this summer:_____
   _____

7. If an emergency arises with your child and we are unable to notify you, name who we should contact:

   NAME:_____ PHONE:_____

   RELATIONSHIP TO CHILD:_____

8. If a critical emergency arises and we are unable to contact you or the above name person, do we have your permission to call your family doctor and follow his recommendations?

   YES _____ NO _____

   DOCTOR:_____ PHONE:_____

_____ _____ _____ _____ _____
DATE PARENT'S SIGNATURE HOME PHONE WORK PHONE E-MAIL ADDRESS

***** IT IS <u>VERY</u> IMPORTANT THAT WE ARE ABLE TO REACH YOU DURING SCHOOL HOURS.***