STUDENT HEALTH HISTORY

Student's name _____ **Birthdate** _____ **Grade** _____ **Sex** _____

Home phone _____ **Cell phone** _____

The following information is needed to provide a safe and healthy environment for your child. If your child has a serious medical condition, it is vital that you discuss this with the nurse, teacher, and/or principal immediately. This information will be confidential and used as needed by the necessary school staff and applicable school volunteers to keep your child safe.

Has your child had any of the following? (check the boxes below for ALL that apply)	Yes ✓	No ✓	Medication required at school or home Yes or No?		If YES, give details/name the medication, dosage, and if used at school (S) and/or home (H)
ADD/ADHD	☐	☐	○	○	
Allergies ☐ Dust, pollen, ragweed, dustmites ☐ Food allergies ☐ Latex ☐ Medication ☐ Insects Triggered by?	☐	☐	○	○	**List ALL environmental, food, insect, medication, and allergies:** **Type of Response:** ☐ Hives ☐ Rash ☐ Itching ☐ Vomiting ☐ Swelling ☐ Difficultly Breathing ☐ Wheezing ☐ Other?_____ Epinephrine auto-injector at home: ☐ Y ☐ N Epinephrine auto-injector at school: ☐ Y ☐ N
Anemia/Sickle Cell Anemia	☐	☐	○	○	
Anxiety/Panic Attack	☐	☐	○	○	
Asthma Is an inhaler used? ☐ Yes ☐ No How often?_____ Triggered by?	☐	☐	○	○	
Bladder Infections	☐	☐	○	○	
Blood Disorders	☐	☐	○	○	
Bone-Joint Disease	☐	☐	○	○	
Bowel Movement Condition	☐	☐	○	○	
Bronchitis/Upper Respiratory	☐	☐	○	○	
Cancer	☐	☐	○	○	
Cerebral Palsy	☐	☐	○	○	
Color Blindness	☐	☐	○	○	
Diabetes Blood sugar checked at school? ☐ Yes ☐ No Insulin taken? ☐ Yes ☐ No	☐	☐	○	○	
Depression	☐	☐	○	○	
Epilepsy/Seizure Date of last seizure_____	☐	☐	○	○	
Fainting Spells (explain)	☐	☐	○	○	
Headaches/Migraines	☐	☐	○	○	

Has your child had any of the following? (check the boxes below for ALL that apply)	Yes ✓	No ✓	Medication required at school or home Yes or No?		If YES, give details/name the medication, dosage, and if used at school (S) and/or home (H)
Hearing Problems/Devices/ Frequent Ear Infections	☐	☐	○	○	
Heart Condition	☐	☐	○	○	
Kidney Trouble	☐	☐	○	○	
Muscle Disorder	☐	☐	○	○	
Neurological Concern	☐	☐	○	○	
Nose Bleeds (frequent)	☐	☐	○	○	
Orthopedic Concerns	☐	☐	○	○	
Physical Activity Limitations	☐	☐	○	○	
Speech Problems	☐	☐	○	○	
Vision Problems Wears: **Glasses** or **Contacts**	☐	☐	○	○	**Eye Dr. name:** Phone #: Last eye exam:
Dental Problems	☐	☐	○	○	**Dentist name:** Phone #: Last visit:

Primary care physician _____ **Phone** _____ **Last visit** _____

Specialist name _____ **Phone** _____ **Last visit** _____

IF STUDENT(S) REQUIRES MEDICATION PRESCRIBED BY A PHYSICIAN, DENTIST, OR OPTOMETRIST AT SCHOOL, PLEASE OBTAIN THE APPROPRIATE FORMS IN THE OFFICE. ALL MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL PHARMACY OR MANUFACTURER'S LABELED CONTAINER.

List any operations, injuries, hospitalizations, or other concerns:

Incident 1: _____ Date _____

Incident 2: _____ Date _____

Comments

In case of emergency, accident, or serious illness to the student named on this sheet in which medical treatment is required, I (parent/guardian) request the school to contact me. If the school is unable to reach me, my signature below authorizes the school to exercise their own judgment in contacting emergency services through 911. The school may make whatever arrangements are necessary to transport the student to a hospital emergency room at my (parent/guardian) expense. This may involve cost.

Parent/guardian name _____

_____

PARENT/GUARDIAN SIGNATURE DATE

Emergency contact _____ **Phone** _____