STUDENT HEALTH HISTORY

Student Name: _____ Sex: M F Birth date:_____

Father:_____phone:_____Mother:_____phone:_____

Emergency Contact: 1st_____phone:_____2nd_____phone:_____

Has your child ever had injury or illness requiring surgery? Yes___ No___ If yes, Please explain below.
Medical Condition_____

Does your child have any of the following conditions?

YES NO

____ ____ ***HAD CHICKEN POX***? What age?_____.
____ ____ ***ALLERGIES*** (i.e., food, medicine, bee stings.) List Allergy_____
____ ____ Is EPI-PEN prescribed? IF YES, Please speak to nurse. Child will need one at school).
Note: (Nurse must have documentation from MD for any modifications in diet for allergies or other).
____ ____ ***ASTHMA*** List medications taken for asthma_____
____ ____ ***Is INHALER Prescribed?*** (IF YES, Please speak to nurse. Child will need one at school).
____ ____ ***DIABETES*** When was it diagnosed?_____Doctor_____
Is INSULIN needed at school? When?_____Type?_____
____ ____ ***HYPOGLYCEMIA*** is a snack needed at school? Yes NO
____ ____ ***ANOREXIA*** Require professional assistance? Yes NO
____ ____ ***HEAD INJURIES*** when?_____number of ?_____
____ ____ ***SEIZURES?*** Date of last seizure_____On Medication?_____
____ ____ ***SLEEP PROBLEMS***? Describe_____
____ ____ ***EAR PROBLEMS Frequent ear infections?*** YES/NO Tubes in ears? YES?NO _____
Are hearing aids needed? YES/ NO Does he/she require sitting close to the speaker? YES/ NO
____ ____ ***FREQUENTLY SICK***? Strep throat? Kidney infection? High fevers? (Circle those that apply)
____ ____ ***RHEUMATIC FEVER*** age of child_____Medication required?_____
____ ____ ***ANEMIA What age?_____*** Re-occuring?_____
____ ____ ***ADD/ADHD age diagnosed?_____*** Is medication needed at school?_____
List current medication_____
____ ____ ***BONE/JOINT PROBLEMS OR FRACTURES*** Is a brace required? YES/NO
What bone or joint and when?_____Left / Right
____ ____ ***DEPRESSION How long?_____*** List medication taken:_____
____ ____ ***EMOTIONAL CONCERNS*** _____

Required Vaccine Doses

Age	DTaP	Polio	Hib	Hepatitis B	Hepatitis A	MMR	Varicella
Preschool	#4	#3	#4	#3	#1	#1	#1
K - 12	#4 or #5	#3 or #4		#3		#2	#1 or #2

CHECK ONE:

_____ Copy of current official documented immunization record attached.
_____ Religious Beliefs exemption form signed by parent/guardian attached.
_____ Medical Exemption form signed by physician and parent/guardian attached.
_____ Signed Laboratory Proof of Immunity form attached.

Please mark the medications you child may take at school if needed:

___Tylenol ___Motrin ___Cough Drops ___Pepto Bismol/ Peppermint/Tums
___ Salves/Ointments ___ Eye Drops ___ Sinus Decongestant
___ No; I do not want my child to receive medication at school.

Students will not receive medication at school unless this paper is signed and on file. You will be required to pick up your student if medication is needed. If student needs medication for extended time or for a chronic condition you must supply the medication and complete a separate form.

Your signature is an informed consent to share this history information with school staff on a need to know basis for Academic success and emergency plans as determined by the school nurse.

Parent Signature: _____ Date: _____
Reviewed by Health Provider: _____ Date: _____