STUDENT HEALTH HISTORY

Student health information within the school is limited to the information necessary to serve the student's educational and health interests.

Student Name_______________________________ **Grade**______ **Date**_________

Please let us know your child's health needs by completing this form.

ق **My child has no health problems which would affect his/her school day.**

ق **My child's health needs include the conditions checked (X).**

ق **Allergies**, please list____
What happens?____
Is EpiPen Prescribed? قYes قNo (If yes, parent must provide EpiPen)

ق **Bee Sting Allergy**, What happens?_______________________________________
Is EpiPen Prescribed? قYes قNo (If yes, parent must provide EpiPen)

ق **Asthma** Is inhaler used? قYes قNo If yes, how often?___________________________
What medications are taken for asthma?_________________________________ ____

ق **Diabetes** What medications are taken?___________________________________
Any special procedures during the school day?__________________________ _____

ق **Hearing Problem**, Please describe_______________________________________

ق **Vision Problem** Wears glasses? قYes قNo Wears contacts? قYes قNo

ق **ADD or ADHD Diagnosed**, What medications are taken?_____________________
Will medication be needed in school? قYes قNo, When?_______________________

ق **Bone/Joint problem or fractures?** Which bone or joint?______________________
Is a brace worn? قYes قNo

ق **Seizures** What type?___________________________ Date of last seizure_________
Medication taken____

ق **Episode of loss of consciousness** When?___________________
Any special treatment?____

ق **Emotional concerns** List____

List any other recurrent medical problem or illness you would like the school to be aware of
____

Name of Student's doctor_________________________ **Phone** _________________
Does your child see a specialist? قYes قNo Name_____________________________
Phone___________________

Please contact school personnel for medication forms if your child needs medication at school, including inhalers for asthma or EpiPen for severe allergic reactions. Your child may carry an inhaler if medically authorized and developmentally appropriate, after informing school personnel.

Health History Informed Consent

Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans.

Parent/guardian signature____ **Date**________________

Phone number______________________