

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.

My child has NO health problems which would affect his/her school day.

My child's health needs include the conditions checked .

- Allergies, please list _____
 - What happens? _____
 - Is EpiPen prescribed? ____ Yes ____ No (If yes, parent must provide EpiPen)
- Bee Sting Allergy ____ Yes ____ No
 - What Happens? _____
 - Is EpiPen prescribed? ____ Yes ____ No (If yes, parent must provide EpiPen)
- Asthma Is inhaler used? ____ Yes ____ No If yes, how often? _____
 - What medications are taken for asthma? _____
- Diabetes
 - What medications are taken? _____
 - Any special procedures during the school day? _____
- Hearing Problem Please describe _____
- Vision Problem Wears glasses? ____ Yes ____ No Wears contacts? ____ Yes ____ No
- ADD or ADHD Diagnosed
 - What medications are taken? _____
- Will medication be needed in school? ____ Yes ____ No When? _____
- Bone/Joint problem or fractures
 - Which bone or joint? _____
 - Is a brace worn? ____ Yes ____ No
- Seizures
 - What type? _____ Date of last seizure _____
 - Medication taken _____
 - Episode of loss of consciousness, When? _____
 - Any special treatment? _____
- Emotional concerns
 - List _____
- 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? ____ Yes ____ No

Specialist's 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 _____ Phone number _____ Date _____