FAYETTEVILLE CITY SCHOOLS HEALTH SERVICES HEALTH HISTORY

Confidential

THIS FORM MUST BE COMPLETED BY A PARENT OR GUARDIAN

Dear Parents/Guardians,

Please complete the information on your child's health history. This information is needed in order that we may give your child the best possible care in the event of an illness or emergency. If your child does have a health condition/concern PLEASE give detailed information about what is needed to give your child the best possible care.

Student Name		(Grade/Teacher	
first		last		
			Physician	
Address		T .1		
Father's Name		Father's Ho	Father's Home Phone	
Father's Work Phone		Father's Ce	Il Phone	
3.6.4. 3.37		N. 4 2 T	, N	
Mother's Name		Mother's H	Mother's Home Phone	
Mother's Work Phone		Mother's Cell Phone		
Brothers and sisters at scho	ool (names and hor	merooms)		
	RENT CANNOT	BE REACHED, PLE	TRST IN CASE OF ILLNESS OR CASE LIST EMERGENCY CONTACTS D.	
1. Name		Phone	Relationship	
2. Name		Phone	Relationship	
3. Name		Phone	Relationship	
	HEA	LTH INFORMATI	ON	
1. Is student under medical including a list of all medical			No If yes, please describe	
2. Has student had any ser No If yes, please des	amila	sses, accidents or bee	on hospitalized recently? Yes	
•	treatments, injection trached). Please l	ons, topical creams an ist all medications an	ents during school hours? This includes nd oral medications. These require a d treatments below.	

4. IS CHILD ALLERGIC TO ANY OF THE FOLLOWING: Foods______ Reaction_____ Treatment____ (Requires a physician statement to be sent to school) Medications______ Reaction_____ Treatment_____ Insects_____ Reaction____ Treatment____ Chemicals _____ Reaction _____ Treatment _____ Seasonal Allergies______ Reaction_____ Treatment____ If you would like for your child to be given the above listed treatment, complete and return the medication consent form. 5. Does student require any of the following: (please mark all that apply) Glasses _____ Contact lenses ____ Hearing aid ____ Wheelchair ____ Crutches ____ Artificial limbs _____ Other (describe) _____ 6. Health Problems: Please mark all that apply and describe the health problem(s) along with any medication or treatment needed. ADD/ADHD ____ HEARING IMPAIRMENT ____ASTHMA/BREATHING PROBLEMS HEMOPHILIA/BLEEDING DISORDER ____ HYPERTENSION/HIGH BLOOD PRESSURE ____BOWEL/INTESTIONAL PROBLEMS CARDIAC/HEART PROBLEMS NEUROLOGICAL/BIRTH DEFECT ____ CANCER/LEUKEMIA ____ PHYSICAL IMPAIRMENT ____ DENTAL PROBLEMS _____ SICKLE CELL ANEMIA DIABETES/HYPOGLYCEMIA SKIN DISORDERS _____ STOMACH PROBLEMS/ULCERS EPILEPSY/SEIZURES/CONVULSIONS ____ URINARY/KIDNEY/BLADDER PROBLEMS HEADACHES - frequent requiring medication _____ HEADACHES -MIGRAINE _____ VISION PROBLEMS **HEADACHES -SINUS** OTHER (PLEASE LIST) Explanation of health problems marked above_____ 7. Does student have any limitations that prevent him/her from participating in physical education or school sponsored activities? If so, please describe and send a physician statement regarding limitations. 8. Please describe any special health needs/services your child may require at school _____ 9. Any additional comments I give consent _____, do not give consent _____ for my child to receive basic first aid at school for minor injuries, insect bites or small accidents that occur. Injuries will be cleaned with soap and water. Hydrogen peroxide may be used if necessary.

Parent's signature

I have read and understand the medication policy

Parent's signature

Date