Fayetteville City Schools Health Services **Confidential**

HEALTH HISTORY

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 middle last

Date of Birth _____Age _____ Sex M or F Physician _____

Legal Guardian _____

Address _____

Father's Name _____ Father's Home Phone _____
Father's Work Phone _____ Father's Cell Phone _____

Mother's Name _____ Mother's Home Phone _____
Mother's Work Phone _____ Mother's Cell Phone _____

Brothers and sisters at school (names and homerooms) _____

ATTEMPTS WILL BE MADE TO CONTACT A PARENT FIRST IN CASE OF ILLNESS OR EMERGENCY. IF A PARENT CANNOT BE REACHED, PLEASE LIST EMERGENCY CONTACTS IN THE ORDER YOU WISH FOR THEM TO BE CONTACTED.

1. Name _____ Phone_____ Relationship _____
2. Name _____ Phone_____ Relationship _____
3. Name_____ Phone_____ Relationship _____

HEALTH INFORMATION

1. Is student under medical treatment at this time? Yes _____No_____ If yes, please describe including a list of all medications given at home.

_____
_____
_____

2. Has student had any serious injuries, illnesses, accidents or been hospitalized recently? Yes___ No___

If yes, please describe _____

3. Is student required to have daily medications or medical treatment during school hours? This includes asthma inhalers, breathing treatments, injections, topical creams and oral medications. <u>These require a medication consent form</u>. Please list all medications and treatments below.

1. _____
2. _____
3. _____

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
____ASTHMA/BREATHING PROBLEMS
____BOWEL/INTESTIONAL PROBLEMS
____CARDIAC/HEART PROBLEMS
____CANCER/LEUKEMIA
____DENTAL PROBLEMS
____DIABETES/HYPOGLYCEMIA
____EPILEPSY/SEIZURES/CONVULSIONS
____HEADACHES – frequent requiring medication
____HEADACHES – MIGRAINE
____HEADACHES – SINUS
____HEARING IMPAIRMENT
____HEMOPHILIA/BLEEDING DISORDER
____HYPERTENSION/HIGH BLOOD PRESSURE
____NEUROLOGICAL/BIRTH DEFECT
____PHYSICAL IMPAIRMENT
____SICKLE CELL ANEMIA
____SKIN DISORDERS
____STOMACH PROBLEMS/ULCERS
____URINARY/KIDNEY/BLADDER PROBLEMS
____VISION PROBLEMS
____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. At times hydrogen peroxide, antibiotic ointment and anti-itch creams may be used if necessary.

_____
Parent's signature Date

I have read and understand the medication policy_____
Parent's signature Date