Houston County Board of Education

Health Related Services

Houston County Student Health Record

Student's Name: _____ Student's ID #: _____DOB:_____

School: _____Grade:_____ Home Room Teacher: _____Date:_____

Does this student have any medical concerns? ☐Yes (complete form) ☐ No (stop form here)

Allergies (medication, food, insect, environment): _____

_____

What kind of reaction occurs with these allergies? _____

☐ **Has your student ever had an Anaphylactic Reaction**? ☐ Y ☐ N ☐ **EMERGENCY Injectable Epinephrine** ☐ Y ☐ N

Student's Current Medical History: **(*Check All That Apply)***

- ☐ ADHD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma: ☐ Y / ☐ N
  - ☐ Inhaler
  - ☐ Seasonal
  - ☐ Nebulizer
  - ☐ Trigger(s): _____
- ☐ Auto Immune Disorder
- ☐ Bleeding Problems/Blood Disorder
- ☐ Blood Pressure:
  - ☐ High
  - ☐ Low
- ☐ Bowel/Bladder Problem
- ☐ Bronchitis *(Chronic)*
- ☐ Cancer
- ☐ Cardiac ☐ Chest Pain
- ☐ Crohns/IBS
- ☐ Convulsions w/Fever
- ☐ Cystic Fibrosis
- ☐ Diabetes:_____ ☐*Glucagon*
  - ☐ Insulin injection or ☐ Pump
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches/Migraines
- ☐ Frequent Nose Bleeds
- ☐ Hearing Problems
- ☐ Heart Murmurs/ Type: _____
- ☐ Heat Exhaustion
- ☐ Hemophilia
- ☐ Limb Loss
- ☐ Missing Organs *(eye, kidney, etc.)*
- ☐ Pacemaker or ☐ Defibrillator
- ☐ Premature Birth (Complications)
- ☐ Rheumatic Fever
- ☐ Seizures: (Type):_____
  - Diastat _____ VNS _____
- ☐ Sickle Cell Condition
- ☐ Skin Condition
- ☐ Speech Difficulty
- ☐ Surgery/Hospitalization
- ☐ Vision Problems/Contacts
- ☐ Weight Problems
- ☐ ***Other:*** _____

Describe how the above checked items affect your student at school (you may use back of form if needed).

_____

_____

_____

Does your student have any potentially life threatening condition(s)?_____ **If yes, please explain**._____

_____

_____

List ***all*** medication(s) the student takes (if taken at school, see Health Tech for form):_____

_____

Has a doctor ordered any special dietary modifications? (See Health Tech for Meal Modification form, updated annually)

_____

_____

Current Physician: _____Family Pediatrician: _____Specialist:_____

Sign if you consent to the exchange of relevant medical information between the student's physician and the school nurse to include diagnosis, prognosis, treatment medical orders and records.

Signature: _____ Relationship to Student: _____

Date: _____

After School Program: _____

After School Daycare: *(Name)* _____

Car Ride: _____

Bus #: _____

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Houston County Board of Education
High-Achieving Students