SCHOOL HEALTH SERVICE HEALTH HISTORY

______________________________ School

______________________________ Grade

Dear Parent:

Tazewell County Public Schools would like for your child to gain the most from his/her school experience. In order to assist in accomplishing our goal, it is necessary to have a current health history. Please complete this form and return it to the school health clinic in a sealed envelope. This form will be kept confidential under the guidelines of the Family Educational Rights and Privacy Act (FERPA).

Student's Name____Sex__________Birth Date________________
(Last) (First) (Middle)

Address____Phone__________________

Father's Name__________________________Mother's Name________________________Brothers________Sister________This child is __________in family.
Number Number (1st, 2nd, etc.)

1. Does your child have health insurance? ☐ Yes ☐ No Dental Insurance? ☐ Yes ☐ No

2. With whom does your child live?____

3. When did your child last see his/her health care provider for a routine check-up/well child exam? Date:______________________ Child's Blood Type____________

4. Please indicate if your child has any of the following health problems (check where appropriate)

Asthma________ Diabetes_________ Blood disorder (anemia, sickle cell anemia, etc.)________ Vision problem________ Recurrent strep throat______

Hearing problem________ Seizures________ Heart problems________ Learning problems_______ Recurrent ear infections________ ADHD_______

Behavioral problems_______ Emotional problems________ Developmental problems________ Meningitis or Encephalitis________

Allergies (be specific) ____________________ Type of Allergic reaction (what happens) ________________________ Any treatment required? __________________

Parents must provide any medications/equipment, health care provider order and written parental permission that their child will need during the school day including any emergency medication.

5. List any medications, vitamins or herbal supplements your child takes:____

6. Does your child require any special services (ex. breathing treatments, tube feedings, etc.)? Explain:_________________________________

7. Has your child been hospitalized since birth?_____ Explain:____

8. Has your child ever had any surgeries?______ Explain:____

9. Please indicate if any close relative in your family has a history of any health problem. Please indicate the relationship to the child (For Example: M - Mother, F - Father, GM - Grand mother, GF - Grandfather, B - Brother, S - Sister, C - Cousin, U - Uncle, A - Aunt).

Asthma________ Diabetes_________ Blood disorder (anemia, sickle cell anemia, etc.)________ Cancer________ High blood pressure______

Hearing problems________ Seizures________ Heart disease________ Learning problems_______ ADHD_______ High cholesterol_______

Emotional problems________ Birth defect________ Mental retardation________ Tuberculosis________

10. Are there any problems in the home which might affect your child's learning?______ Explain______________________________________

11. If your child has a medical problem, we may need to contact his/her health care provider for information, treatment orders, etc. Check here if you give permission for the school health assistant, nurse or nurse practitioner to contact your child's health care provider if needed. ☐ es ☐ No If you indicated "Yes", please list your child's health care provider and phone number.

____ Phone Number______________________________

12. We may need to share important health information with some school personnel such as your child's teacher, bus driver, principal, etc. Do we have your permission to share important health information with school personnel who need to know? ☐ Yes ☐ No If your child rides a bus, what is the bus number? _____

13. Is there anything more about your child's health that you think is important for us to know?____
(Please explain on separate sheet and attach to this form)

Signature:____Relationship to child:________________Date:__________________

The Tazewell County Public School District is certified to provide EPSDT (Early Periodic Screening Diagnosis and Treatment) screening.