HEALTH HISTORY FORM

RETURN AT REGISTRATION EACH YEAR

CONTACT THE SCHOOL NURSE DIRECTLY EACH YEAR IF YOUR CHILD HAS: INHALER, NEBULIZER, Epi-Pen, HEALTH PLAN, OR DIETARY ACCOMMODATIONS

Student Name: ______________________________ **Birth Date:**__________ **Grade:**__________
Last First

Primary Care Provider *(Family Doctor)* **or Specialist:**______________________________ Phone Number:__________

Dentist *(in case of dental emergency):*______________________________ Phone Number:__________

EMERGENCIES Does the student have a known health problem that could result in an emergency? ☐Yes ☐No

If yes, describe______________________________

RIDES THE BUS OR SHUTTLE? ☐Yes ☐No Health info the driver should know:______________________________

HEALTH CONCERNS **Mark ☒ the box and explain if your child has a history of, or now has, the following conditions or concerns.**

☐ **ADD/ADHD**______________________________

☐ **Autism**______________________________

☐ **Life Threatening Allergy**

☐Epi-Pen at home ☐Epi-Pen at school

☐Bees/Wasps ☐Food______________________________

☐Medication______________________________

☐Other______________________________

**What happens when exposed?*______________________________

☐ **Seasonal Allergies**: ☐Mild ☐Moderate ☐Severe

Symptoms______________________________

Medication taken?______________________________

Uses inhaler for seasonal allergies?__________

☐ **Other Allergy**______________________________

**What happens when exposed?*______________________________

☐ **Asthma**

Triggers______________________________

☐Inhaler at school ☐Inhaler at home

☐Nebulizer at school ☐Nebulizer at home

How often is inhaler/ neb typically used?

____

☐ **Diabetes** ☐Type I ☐Type II ☐Uses Insulin

☐ **Other Developmental Concern**______________________________

☐ **Dietary Concern**______________________________
*Dr. Signature form is required for meal accommodations.
*Contact the School Nurse directly for form.

☐ **Emotional/ Behavior Concern**______________________________

☐ **Eyes/ Vision**__________Wears Glasses? ☐Yes ☐No

Glasses should be worn: ☐Reading only ☐At all times

Last vision appointment date:______________________________

☐ **Heart/ Murmur**______________________________

☐ **History of Head Injury / Concussion**

Date of diagnosed concussion______________________________

☐ **Muscle/Bone/Joint**______________________________

☐ **Nose / Sinus**______________________________

☐ **Seizures**

Type of seizures______________________________

Date of last seizure______________________________

Emergency Med at school?______________________________

☐ **Physical Limitations**______________________________

☐ **Other**

MEDICATIONS

Does your child take medications on a routine basis? Yes No If yes, is it taken during school hours? Yes No

List ALL medications that the student takes every day or when needed:

Name of medication:______________________________Purpose of medication: ______________________________
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Name of medication:______________________________Purpose of medication:______________________________

Contact the School Nurse or school office regarding the policies if your child must take medication at school.

I authorize the school to contact provider(s) named above in case of emergency, for necessary care related to a health concern for my child, or regarding their diagnosis or health plan. I will notify the school if my child's health status changes, or there is a change in medications. The information will be shared only with appropriate school personnel who need to know.

______________________________ ______________________________ ______________
Parent Signature Printed Name Date

Updated 1-29-2019