HEALTH HISTORY FORM

RETURN AT REGISTRATION EACH YEAR

CONTACT THE SCHOOL NURSE DIRECTLY EACH YEAR IF YOUR CHILD HAS:
INHALER, NEBULIZER, EpiPen, HEALTH PLAN, or needs DIETARY ACCOMODATIONS

Student Name _____ **Birth Date** _____ **Grade in the Fall** _____
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**
- ☐ EpiPen at home ☐ EpiPen at school
- ☐ Bees/Wasps ☐ Food _____
- ☐ Medication _____
- ☐ Other _____

What happens when exposed? _____

☐ **Allergy to Dogs?** *There are therapy dogs in the buildings*

☐ **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 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 Schl Nurse or Dietary Dept directly for form.**

☐ **Ear / Hearing** _____ ☐ **Ear tubes Rt Lt**

☐ **Emotional/ Behavior Concern** _____

☐ **Eyes/ Sight** _____ Wears Glasses? Yes ☐ No ☐
Glasses should be worn: ☐ Reading only ☐ At all times
Last vision appointment date: _____

☐ **Heart/ Murmur** _____

☐ **Hx 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: _____

Name of medication _____ Purpose of medication: _____

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.

OVER! COMPLETE MED PERMISSION FORM - SIDE TWO→

_____ _____ _____
Parent Signature Printed Name Date