Student Health History

Health Services requires an updated Health History each school year. Information provided will be shared with pertinent staff members to provide safe, informed care for your student while at school. If your student's health status changes, you will need to provide the School Nurse with updated information.

Name_____ Grade_____ Birth Date_____ Sex: ☐Male ☐Female

☐ **Student has no known health condition.** Complete Over-the-Counter Medication Authorization on bottom of form.

Health History

Life Threatening Allergic Conditions (check all that apply)

Medication required ☐Epinephrine ☐Diphenhydramine/Benadryl

☐Severe allergy to Bug bites/Insects: _____

☐Severe allergy to Tree nuts/Peanuts: _____

☐Severe allergy to Food products: _____

☐Other severe allergies affecting school: _____

Please check the box if your child has a history of any of the following. Please explain below.

☐Asthma	☐Emotional Concern	☐Seizures
☐Attention Concern (ADD/ADHD)	☐Headaches/Migraines	☐Skin Concern
☐Behavioral Concern	☐Head Injury	☐Stomach/Intestinal Disorder
☐Blood Disorder	☐Hearing Concern ☐Hearing Aids	☐Vision Concern ☐Glasses/Contacts
☐Cardiovascular/Heart Concern	☐Kidney/Bladder Disorder	☐Currently under a physician's care
☐Developmental Delay	☐Muscle/Joint/Bone Disorder	☐Past Major Illness/Injury
☐Diabetes ☐Type 1 or ☐Type 2	☐Nervous System Disorder	☐Past Hospitalizations/Surgeries

Explain any of the above checked items: _____

_____

_____

Describe any physical conditions/disabilities not listed above: _____

_____

Medications (prescription, supplements, and over-the-counter) If more room is needed use the reverse side.

Medication (s) name	Diagnosis or symptoms requiring medication

My student requires medication(s) at school: ☐ YES*

**A current medication authorization form must be on file before any medications will be given at school.*

Over-the-Counter Medication Authorization

I WILL ALLOW the school nurse and/or authorized personnel to give my child the following:

Acetaminophen/Tylenol	☐ Yes	☐No
Ibuprofen/Advil	☐ Yes	☐No
Cough drops	☐ Yes	☐No
Antacid/Tums	☐ Yes	☐No

Today's Date _____

Parent/Guardian Name_____

Parent/Guardian Signature_____

3/2020