

HEALTH HISTORY School Year 2011-2012

This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health of the student. It is important that the questions be answered completely and accurately.

Student's Name _____ DOB _____ Sex M F Grade _____

Parent/Guardian _____ Address _____ Zip _____

Home phone _____ Mother's work phone _____ Dad's work phone _____

Student lives with ___ Both Parents ___ Mother ___ Father ___ Guardian

If a parent cannot be reached at any of the above phone numbers, whom should we contact in an emergency?
_____ Phone _____ Relationship to student? _____

Is student new to school district? NO YES If yes, list school district last attended _____

Allergies

Allergy to medication No Yes If yes, please list _____
Allergy to bee stings No Yes If yes, what type of reaction _____
Allergy to latex No Yes _____
Allergy to any foods No Yes List foods _____
Emergency Procedure Needed _____

Health Concerns

Please check any health concerns listed below that your student might have.

- | | | |
|---|--|--|
| <input type="checkbox"/> Vision Glasses Yes No | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Brain/Neurological Disorder |
| <input type="checkbox"/> Hearing Aid Yes No | <input type="checkbox"/> Headaches Type _____ | <input type="checkbox"/> Anemia/Blood Disorder |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Seizure Activity | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Attention Deficit Disorder/ADHD | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes/Endocrine Disorder |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Urinary/Kidney Disease | <input type="checkbox"/> Stomach/Intestinal Disorder |
| <input type="checkbox"/> Musculoskeletal Disorder | <input type="checkbox"/> Degenerative Disorder | <input type="checkbox"/> Other (Please list) |
| <input type="checkbox"/> Allergies (other than above) | (Arthritis, MS, MD, etc.) | |

Please fully explain any answers checked above: _____

Does the above health concern require special attention at school? ___ No ___ Yes

Any other factors that the school nurse, counselor or your child's teacher(s) should know of which might affect the student's school experience? _____

Medication taken during the school year at home (include non-prescription): _____
Reason for medication: _____

Medication taken during the school year at school: _____
Reason for medication: _____

Describe any ongoing behavioral, emotional or psychological concerns your child has: _____

Doctor Visits

Has the student seen a doctor during the last year for:

| | | | |
|---------------|----------------|------------|--------------|
| Physical Exam | ___ No ___ Yes | Date _____ | Doctor _____ |
| Dental Exam | ___ No ___ Yes | Date _____ | Doctor _____ |
| Vision Exam | ___ No ___ Yes | Date _____ | Doctor _____ |

Insurance Information

Insurance/Medicaid _____ Member# _____ Group# _____

I give my permission for confidential and discreet use of the above information to meet my child's health and educational needs at school.

Parent/Guardian Signature _____ Date _____

Original Copy of Health History should be filed in the above named student's folder in the health services office. 5/07