Parent/Guardian – Please complete this form, sign, and return to your child's school immediately.

STUDENT HEALTH HISTORY

School Staff – Please put this form in the school nurse's mailbox as soon as you receive it!!

Student's Name_____ **Date of Birth**_____ **School**_____

Homeroom/Lead Teacher_____ **Grade**_____ **School Year**_____

Child's Doctor:_____ **Insurance?** _____ **Parent Phone:** _____

Is your child on any prescription medications that will need to be given at school? ☐-No ☐-Yes *****
If **YES, a medication or Action form must be completed and signed by the parent/guardian and physician each year or when changes in the plan take place*

☐ ***My child does not have any health conditions***

Does your child have any of the following diseases or disorders? (check all that apply)

1-Endocrine disorders
- ☐ Diabetes
  - ☐ Requires insulin
  - ☐ Does not require insulin
- ☐ Hormonal
- ☐ Thyroid
- ☐ Other _____
- ☐ Medication _____

2-Lungs/Respiratory disorders
- ☐ Asthma
  - ☐ Medication _____
  - ☐ Inhaler/nebulizer used last 2 years?
- ☐ Tracheostomy
- ☐ Other _____

3-Allergies
- ☐ Medication: _____
- ☐ Bees
- ☐ Food (list)_____
- ☐ Latex
- ☐ Seasonal/Environmental
- ☐ Other _____
- ☐ Non-life threatening
- ☐ Life threatening
- ☐ Need Epinephrine (Epi- pen)

4-Head/Neurological
- ☐ ADD ☐ ADHD
- ☐ Autism/Asperger syndrome
- ☐ Concussion: (date) _____
- ☐ Cerebral Palsy
- ☐ Migraines
- ☐ Spina bifida
- ☐ Tourette's Syndrome
- ☐ Traumatic brain injury (TBI)
- ☐ Seizures
- ☐ Shunt
- ☐ Vagal nerve stimulator
- ☐ Other _____
- ☐ Medication _____

5-Cancer
- ☐ Type _____
  - ☐ Date diagnosed _____
- ☐ Indwelling port

6-Blood disorder
- ☐ Anemia
- ☐ Hemophilia
- ☐ Sickle cell disease ☐ trait
- ☐ Thalassemia
- ☐ Other _____

7-Heart condition
- ☐ High blood pressure
- ☐ Irregular heart rhythm
- ☐ Medication _____
- ☐ Other _____

8-Bone/Joint
- ☐ Arthritis
- ☐ Lupus
- ☐ Use crutches, braces, walker, wheelchair
- ☐ Other _____

9-Kidney/Bladder
- ☐ Catheter
- ☐ Disposable briefs
- ☐ Urinary incontinence
- ☐ Other _____

10-Gastrointestinal
- ☐ IBS/Irritable Bowel/Crohn's Disease
- ☐ Feeding tube
- ☐ Other _____

11-Ears
- ☐ Hearing impaired
  - ☐ Cochlear implants
  - ☐ Wears hearing aids
- ☐ Other _____

12-Eyes
- ☐ Prosthetic eyes
- ☐ Vision impaired
  - ☐ Contacts
  - ☐ Glasses
- ☐ Other _____

13-Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other _____

14-Behavioral/Emotional
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Eating disorder
- ☐ OCD ☐ ODD ☐ PTSD
- ☐ Other _____

15-Muscular
- ☐ Muscular dystrophy
- ☐ Multiple sclerosis
- ☐ Other _____

16-Genetic/chromosomal

_____

17-Other/Major Injuries

_____

18–Medications not given at school:

_____

_____

_____

_____

☐ **Requires Food modifications**
(attach doctor's diet order)

_____

Parent/Guardian Signature: _____ **Date:**_____

******Please write additional health information beside "Other Conditions" above or contact our school nurse to discuss.***

******I give permission for the school nurse to exchange and fax information with my child's physician(s) regarding the health condition(s) above.**

Parent/Guardian Signature:_____ **Date:**_____