SHAWNEE MISSION
SCHOOL DISTRICT

Health History Form

Student's Name	Birthdate / /	Age	Sex (M/F)	Grade

Mother/Guardian _____	Father/Guardian _____
Cell Phone: (____)_____-_____	Cell Phone: (____)_____-_____
Home Phone: (____)_____-_____	Home Phone: (____)_____-_____
Work Phone: (____)_____-_____	Work Phone: (____)_____-_____

Name of Physician _____ Phone (____)_____-_____
Name of last school attended _____ City/State _____

Special Healthcare Planning/Serious Health Conditions Please notify the school nurse of a serious or life threatening health condition prior to the start of school.

☐ Allergy/Anaphylaxis: My child has severe allergy/anaphylaxis requiring an Epi Pen/Auvi-Q prescription.
Describe the allergy (food, insect, etc.) _____
☐ Asthma: ☐ Yes ☐ No My child uses rescue inhaler routinely for asthma symptoms
☐ Yes ☐ No My child has been hospitalized in the past year for asthma
☐ Yes ☐ No My child has needed steroids (prednisone) for asthma symptoms in the past year
☐ Diabetes: Date of diagnosis: _____ My student has: ☐ insulin pump ☐ insulin pen ☐ injected insulin
☐ Seizure Disorder: My student needs emergency medication for seizures. Name of medication: _____
☐ ☐ Other: My child has special health care needs: wheel chair, tube feedings, breathing tube, catheter, intravenous tubes, other. Please describe your child's condition and healthcare needs: _____

Other Health Conditions Check any condition your child currently has or has had in the past:

☐ ADD/ADHD	☐ Depression/Anxiety	☐ Orthopedic/Bone
☐ Allergies ☐ Seasonal	☐ Dental ☐ Braces/Orthodontia	☐ Serious Injury
☐ Dietary Restrictions	☐ Ear Infections ☐ Ear Tubes	☐ Surgery(s)
☐ Bladder/Bowel	☐ Hearing Impairment ☐ Hearing Aides	☐ Social/Emotional/Behavioral
☐ Blood Disorder	☐ Headaches/Migraines	☐ Stomach Aches
☐ Concussion	☐ Heart Disease	☐ Throat Infections
☐ Cancer	☐ Kidney Disease	☐ Vision: ☐Glasses ☐Contacts

Explain any health condition(s) checked _____
Does your child require any restriction of physical activity in school? ☐ No ☐ Yes, specify nature and duration of restriction:
_____

Emergency Contact (if parent/guardian cannot be reached)

1. Name _____ Relationship _____ Phone (____)_____-_____
2. Name _____ Relationship _____ Phone (____)_____-_____

Preferred Hospital _____ City/State _____

Statement of Consent *In order to better serve the healthcare needs of my child, I give my permission for the transfer of health information to the school and any other appropriate school or healthcare professionals including emergency personnel. This includes release of school immunization records to the KS Immunization Program, and the immunization registry for the purpose of assessment, reporting, and prevention of disease. I authorize school personnel to obtain emergency medical care for my student in the event I cannot be reached.*

Print Parent/Guardian Name	Signature of Parent/Guardian	Date / /

Revised 3/2017