

PASCO SCHOOL DISTRICT



HEALTH HISTORY

To be completed by parent/guardian

Today's Date \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Teacher \_\_\_\_\_

Name of Student \_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex:  Male  Female

MEDICAL HISTORY (check all that apply)

Please explain any yes answers.

Life Threatening Condition  No  Yes

If yes, by State Law, your child may not attend school until the health care providers orders for this condition have been provided. Please contact the School Nurse.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Asthma  No  Yes

\_\_\_\_\_

Bee/insect allergy (needs special care)  No  Yes

\_\_\_\_\_

Severe allergies – affecting school  No  Yes

\_\_\_\_\_

Problems with pregnancy/delivery  No  Yes

\_\_\_\_\_

Concerns with early development  No  Yes

\_\_\_\_\_

Frequent ear infections  No  Yes

\_\_\_\_\_

Hearing concerns  No  Yes

\_\_\_\_\_

Speech difficulties/hoarseness  No  Yes

\_\_\_\_\_

Severe headaches  No  Yes

\_\_\_\_\_

Seizures  No  Yes

\_\_\_\_\_

Neurological condition  No  Yes

\_\_\_\_\_

ADD/ADHD (diagnosed by whom)  No  Yes

\_\_\_\_\_

Heart condition  No  Yes

\_\_\_\_\_

Diabetes  No  Yes

\_\_\_\_\_

Blood disorder  No  Yes

\_\_\_\_\_

Orthopedic condition  No  Yes

\_\_\_\_\_

Chronic condition/disability  No  Yes

\_\_\_\_\_

Vision concerns  No  Yes

Glasses  Contacts Other \_\_\_\_\_

Serious illness/injury/surgery  No  Yes

\_\_\_\_\_ Date \_\_\_\_\_

Other health concerns  No  Yes

\_\_\_\_\_

Any condition which limits participation in regular P.E.?  No  Yes

Limits are \_\_\_\_\_

MEDICATION

Is medication needed at home?  No  Yes

Name of medication(s) \_\_\_\_\_

Is medication needed at school?  No  Yes

Name of medication(s) \_\_\_\_\_

**State law requires written permission from a health care provider and parent before any medication, prescription or over-the-counter, may be taken at school. A form is available from the school office.**

Is there anything you want to tell us about your child which you feel will help school staff to better understand and work with him/her?

I understand that the information given above will be shared with appropriate school staff who needs to know in order to provide for the health and safety of my child.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Healthy Students Make Better Learners