CONFIDENTIAL STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child had any of the following medical concerns?	**YES**	**NO**	**COMMENTS Please specify concerns**
ADD or ADHD			
Allergies			
Asthma or other Respiratory			
Bone or Muscle Condition			
Cardiovascular (heart and blood vessels)			
Concussion or serious head injury (if so, how many?)			
Dental			
Diabetes			
Ears/Hearing			
Emotional or Mental Health			*If yes, are outside services involved?*
Eye/Vision			
Gastrointestinal (digestive system)			
Infectious Disease History			
Neurological (such as headaches, seizures)			
Reproductive System			
Skin			
Urinary (bladder)			
Other			

Medications:
Please list all medications your child takes both REGULARLY and AS NEEDED: _____

_____

Medications that are (or may be) needed during the school day:

_____

PLEASE TURN OVER 

PERMISSION TO EXCHANGE CONFIDENTIAL INFORMATION

This form allows for the exchange of confidential information between the listed service providers and the school nurse for the purpose of providing appropriate health care and services to:

Student: _____ D.O.B.:_____/_____/_____

_____

Medical Provider

_____

Medical Provider

_____

Medical Provider

As the parent/guardian of the above student, I understand that this exchange will involve only necessary information and include only individuals who need to know the information in order to provide appropriate services to the student.

_____ _____

Signature of parent or guardian Date

Comments: _____

_____

Belgrade District School Nurses: ***Jennifer Rigard, RN and Connie Bengtson, RN***