Grade _____

Student Health History

2020-2021

To be completed by Parent or Guardian at time of enrollment

Name of Student_____ **Date of Birth**_____

Male or Female (circle one) **School** _____

Health Concern	Yes	No	Explain
Allergy to Food/Insect	☐	☐	
Asthma – Uses Inhaler	☐	☐	Inhaler at school? Yes ☐ or No ☐
Bleeding Disorder	☐	☐	
Cancer	☐	☐	
Diabetes Type I or II	☐	☐	
Seizures	☐	☐	
Other Issues	☐	☐	

If **allergy** to food or insect, what is the reaction? _____

*Food allergy requires a physician statement for cafeteria to recognize the allergy.

Does your child have Epinephrine for any allergic reaction? **Yes** ☐ or **No** ☐

Does your child have any special health care needs? **Yes** ☐ or **No** ☐

If **Yes**, please explain: _____

Are there any other medical problems that you would like to share with Health Services?

_____

Medications:

What medications does your child take regularly? _____

What medications will your child take at school? _____

For your child to take **prescription medication** at school the parent/guardian must have a completed Medication Consent Form filled out and signed by the physician and parent on file at the school site.

For a child to take **over the counter medication,** including cough drops and sun screen at school, the parent/guardian must have completed a Medication Consent Form and have it on file at the school site.

Screenings:

The school nurses or other designated screening personnel may screen for hearing, vision, height, weight, blood pressure, pulse and dental throughout the year. You may opt out of the screenings by writing opt out on this form.

Parent/Guardian Signature_____ **Date**_____

Parent/Guardian printed name:_____ **Parent/Guardian Phone**_____

Emergency Contacts

Contact Name_____ Phone number_____

Contact Name_____ Phone number_____

Contact Name_____ Phone number_____

Name of Student (Last) _____ (First) _____