

HEALTH HISTORY

STUDENT HEALTH INFORMATION *Please answer the following questions pertaining to your child. This form must be completed in black or blue ink.*

Student's Legal LAST Name	Suffix	Student's Legal FIRST Name	Student's Legal MIDDLE Name
ADHD/ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is medication needed at school?*	
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	What is your child allergic to?* Please list:	
		Describe allergic reaction:	
		Has your child received emergency care in the past related to allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Does your child have an Epi Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Will your child need an Epi Pen at school?*	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of last attack*:	
		Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Medication taken at home:	
		Is medication needed at school?*	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child use insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Does your child use oral medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is medication needed at school?*	
		Is blood sugar monitoring needed at school?*	
		Is Glucagon injection needed at school?*	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe seizure*:	
		Does your child take seizure medication at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is medication needed at school?*	
		Is your child currently under a doctor's care for seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		When was his/her last seizure?	
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is medication needed at school?*	
Head Injury/ Concussions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child been diagnosed with a concussion in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date of injury:	
		Is your child currently under a doctor's care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision/Eye Concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please list any vision concerns:	
		Does your child wear glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing/Ear Concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child have a known hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, please indicate affected ear: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
		Does your child wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, please indicate which ear: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list condition*:	
		Does your child take medication for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is exercise limited?*	
Mental/Emotional Concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list services that have been provided for your child*:	
Other Health Concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe*:	
		Will your child need special procedures performed at school?*	
		Type of health care procedure needed:	

Does your child take medications daily at home? Yes No If "yes," please list:

Special Instructions for teacher and/or school nurse:

***ADDITIONAL FORMS ARE REQUIRED TO BE COMPLETED BY A PHYSICIAN AND REVIEWED BY THE SCHOOL NURSE BEFORE ANY HEALTH ACCOMMODATIONS CAN BE MADE. SOME ACCOMMODATIONS MAY REQUIRE A DELAYED ENROLLMENT DATE.**

Parent/Legal Guardian Signature: _____ Date: _____