Student Medical History

To be filled out and signed each school year

Student's Name: _____ School: _____Grade: _____

Complete the following checklist by indicating any of the following student conditions.

▢ This child has no health needs (please be sure to sign this form).

Allergies

▢	Environment	Please list:
▢	Food	Please list:
▢	Insect/Bees	Please list:
▢	Medications	Please list:
▢	Other	Please list:

Restrictions: Please list any restrictions your student currently has.

▢ **Food:**

▢ **Activity** (Requires Provider's Order) **:**

Does your child have an IEP ▢ Yes ▢ No If yes, diagnosis: _____

Current Medications *Please provide information in boxes*

Med #1:	Dosage:	Condition:
Med #2:	Dosage:	Condition:
Med #3:	Dosage:	Condition:

**If medications will be administered during school hours, a *provider's order will be needed each school year*.
The Prescription Medication Form can be found on the district website:

https://www.usd385.org/departments/nursing.**

Health Conditions

▢ ADD/ADHD	▢ Depression	▢ Hypoglycemia
▢ Anxiety	▢ Diabetes	▢ Headaches/Migraines
▢ Asthma	▢ Digestive/Bowel Disorders	▢ Mental Health Disorders
▢ Autism/Aspergers	▢ Down Syndrome	▢ Reflux
▢ Bladder/Kidney Disorder	▢ Eating Disorder	▢ Skin Disorders
▢ Blood Disorder	▢ Epilepsy/Seizure Disorder	▢ Traumatic Brain Injury/Concussion
▢ Bone/Joint/Muscular Disorder	▢ Heart Disease	▢ Other

Please provide additional information regarding above positive answers here:

_____

_____

_____

Vision and Hearing

▢ Glasses/Contacts	▢ Hearing Aids
▢ Vision Concerns	▢ Hearing Concerns

▢	I acknowledge that the above information relating to the health of my child is current	Signature: Date:

Parent/Guardian Contact Information

Student's Full Name: _____ Grade: _____

Parent/Guardian Name: _____

Address: _____ Phone: _____

Business Phone: _____ Emergency Phone: _____