



# Personal Health History 2024-25

Student Name: \_\_\_\_\_ Gender: \_\_\_\_ DOB: \_\_\_\_\_ Gr: \_\_\_\_

Phone: \_\_\_\_\_ May nurse text?  YES  NO

My child has no medical problems that impact the school day.

Does the student have a 504?  YES  NO

Does the student have an IEP?  YES  NO

I believe my child's medical condition(s) substantially limits one or more of his/her major life activities.

**Please list any severe life-threatening allergies that require medication**

Please list specifics

Needs Epi-pen for: \_\_\_\_\_

**Please check the boxes if your child has any of the following issues**

ADD/ADHD  Head Injury/Concussion  Lung Disease  History COVID  Migraines with prescription med

Psychological/Psychiatric  Has medical diagnosis for Dyslexia  Has medical diagnosis of Color Blindness

Describe: \_\_\_\_\_

Allergies non-life threatening

Describe: \_\_\_\_\_

Seizure

Emergency Seizure Medication: \_\_\_\_\_

Asthma Has inhaler  YES  NO

Autism  Cystic Fibrosis

Sickle Cell  Disease or  Trait

Cancer Type: \_\_\_\_\_

Diabetes  Type I  Type II

Special procedures needed \_\_\_\_\_

Other \_\_\_\_\_

Student is a Parent

Individual Health Plans should be in place for students with conditions like Asthma, Diabetes, Seizures and Severe Allergies. Some of these health plans require the signature of a physician. To ensure the safety of your child, please contact your school nurse as soon as possible to complete these plans.

*To ensure the care of my child, I read and agree that pertinent health information be provided to appropriate school staff. This will be done only on a 'need to know' basis, in a confidential manner. I agree that the school nurse may consult with my child's family physician(s) about the above medical condition(s). I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of the child. I will furnish the school with a current telephone number and address in case of an emergency. The above permission will be valid for one year from the date below unless I revoke the permission in writing. In case of an emergency involving your child, it is the policy of this school cooperation to call a doctor, and only in extreme cases will your child be taken to the hospital or 911 contacted.*

Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_