PORTLAND PUBLIC SCHOOLS

Student Health History

Date form received by school: _____

Student Name: _____ DOB: _____

School: _____ Grade: _____Teacher: _____

To provide a safe environment for your child, it is important that we have an understanding of your child's health status. Please check the boxes of medical conditions that your child has been diagnosed with. This form must be completed and returned to school annually.

Health History:

Health Condition:	**Yes:**	**Health Conditions Cont:**	**Yes:**
ADD/ADHD (describe in comments)	☐	Dietary Concerns	☐
Asthma	☐	Ear/Hearing Problems	☐
Behavior Concerns	☐	Eye/Vision Problems/Glasses/Contacts	☐
Blood Disorder (list in comments)	☐	Frequent Headaches	☐
Bone/ Joint Problems	☐	Frequent Stomach aches	☐
Brain (injury, condition, surgery)	☐	Heart Health Condition (describe in comments)	☐
Cancer	☐	Physical Disabilities (describe in comments)	☐
Chronic Diarrhea or Constipation	☐	Seizure disorder (list date of last seizure in comments)	☐
Chronic Respiratory Problems	☐	Skin Condition (Eczema, etc.)	☐
Diabetes	☐	Urinary/Kidney Condition (describe in comments)	☐
Dental Concerns	☐	Other health concerns not listed: (list in comments)	☐

Comments:

Allergies:

Health Condition:	**Yes:**	**Reaction Type (circle symptom your student experiences)**
Food Allergy (describe in comments)	☐	Hives Swelling Nausea/vomiting Diarrhea Difficulty in Breathing Other
Bee Sting Allergy	☐	Hives Swelling Nausea/vomiting Diarrhea Difficulty in Breathing Other
Latex Allergy	☐	Hives Swelling Nausea/vomiting Diarrhea Difficulty in Breathing Other
Seasonal Allergies	☐	Hives Swelling Nausea/vomiting Diarrhea Difficulty in Breathing Other
Other : _____	☐	Hives Swelling Nausea/vomiting Diarrhea Difficulty in Breathing Other

Comments/ Explanation of how you provide treatment at home for the allergy:

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Emergency Medications for Allergies, Seizures, Asthma, Diabetes:	Yes:	No:
Epi-Pen/AUVIQ:	☐	☐
Cetirizine/Zyrtec/Benadryl:	☐	☐
Diastat/Valtoco:	☐	☐
BAQSIMI:	☐	☐
Glucagon:	☐	☐
Inhaler:	☐	☐
Other:_____	☐	☐

Medications	Yes:	No:
Does student take routine medications? (list in comments section along with health condition it is taken for)	☐	☐
Will medication be given at school?	☐	☐

Other Health Information	Yes:	No:
Do your child's health problems affect activities of daily living or school participation? (explain in comments section)	☐	☐
Does your child have a waiver for Immunizations?	☐	☐

Comments:

Parent/Guardian Signature _____Date_____

By typing my name I am signing this document

Printed Name of Parent/Guardian_____

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