ROBERTSON COUNTY SCHOOL NURSING SERVICES

2024 – 2025 Student Health History Form

Student Name:	**Grade:**	**DOB:**
Address:		
Parent Name (Please Print):	**Parent Phone #:**	

Emergency Contact Information		
Emergency Contact Name	**Relationship to Student**	**Phone Number**
1.)		
2.)		
3.)		

1. **Has the student been diagnosed with any medical condition?** **YES** **NO**
   Please circle: Asthma Diabetes Seizures
   Please list any other medical condition or information: _____
   Has the student been prescribed Asthma medication? **YES** **NO**
   Has the student been prescribed seizure medication? **YES** **NO**
   - **If medication will be required at school, the parent/guardian must provide the medication, doctor's order and parental consent.**
   - **Please contact the school nurse for the correct forms.**

   Please list type of seizures: _____
   Date of last seizure: _____
2. **Does the student have any significant allergies to foods or insects?** **YES** **NO**
   Please list the specific allergy and reaction if exposed to their allergen: _____
   _____
   Does the student have an Epi-pen prescribed? **YES** **NO**
   - **If an Epi-pen will be required at school, the parent/guardian must provide the Epi-pen, doctor's order and parental consent.**
   - **Please contact the school nurse for the correct forms. Food allergies require a doctor's order on file.**
   - **Please see the school nurse for the correct documentation.**
3. **Is the student currently taking medications?** **YES** **NO**
   Name of medications: _____ When taken: _____
   - **If medication will be required at school, the parent/guardian must provide the medication, doctor's order and parental consent.**
   - **Please contact the school nurse for the correct forms.**
4. **Has the student had any of the following?**
   Please circle: Concussion Fainting Loss of Consciousness Dizziness
   Bone break/fracture Dislocation
   Please describe: _____
   Date Occurred: _____ Type of treatment received: _____
5. **Has the student had surgery or been hospitalized for anything other than those issues listed above?** **YES** **NO**
   Date: _____ Please describe: _____
6. **Is the student currently under a doctor's care for anything other than routine visit?** **YES** **NO**
   Please explain: _____
7. **Has the student been diagnosed with any behavioral/emotional issues?** **YES** **NO**
   Please explain: _____
8. **Does the student have any hearing problems or wear hearing aids?** **YES** **NO**
   Please explain: _____
9. **Has the student had any recent immunizations?** **YES** **NO**
   - **If yes, please provide an updated copy of the immunization record to the school nurse**
10. **Is there any reason the student is unable to participate in Physical Education class?** **YES** **NO**
    - **If yes, please explain: _____**

Name of student's doctor: _____Date of last visit: _____

**** Except for emergency medications (Inhalers, Epi-pens, Glucagon) which are accompanied by a doctor's order, BOARD POLICY DOES NOT ALLOW STUDENTS TO CARRY ANY MEDICATION WITH THEM AT SCHOOL!! Both prescription and over the counter medications require specific documentation to be on file with the nurse. If your child requires medication at school, please contact the school nurse for the appropriate documentation.**

**** Parents are responsible for notifying the school nurse of any health developments that occur throughout the school year.**

**** Health Consent: Your signature on this document gives consent for the school nurse or other persons acting on behalf of the school system to provide basic health services including treatment of illness, injury and/ or other non-emergent care. Your signature also permits the school nurse to share your child's health information with school staff and healthcare providers, on a need-to -know-basis, to best protect your child in the school environment.**

PARENT/GUARDIAN SIGNATURE_____DATE _____