

# Oakdale Joint Unified School District

168 South Third Avenue, Oakdale, California 95361

(209) 848-4884 ♦ Fax (209) 848-9546



## STUDENT HEALTH HISTORY

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

| YES | NO | Does Your Child:                                                                                                                                                                                                                               |                                                                                                                                        |
|-----|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
|     |    | Have Vision Deficit<br><input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Color Blind                                                                                                                                       | If yes, date of last of exam: _____                                                                                                    |
|     |    | Wear hearing aids or have a hearing problem                                                                                                                                                                                                    | If yes, please explain: _____                                                                                                          |
|     |    | Have allergic reactions (Check all that apply)<br><input type="checkbox"/> Bees/Insects <input type="checkbox"/> Food <input type="checkbox"/> Medication<br><input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Other: _____ | If yes, specify type of reaction _____<br>Specify Food _____<br>Specify Medication: _____                                              |
|     |    | Have a Prescribed Epipen?                                                                                                                                                                                                                      | Physician orders needed for EpiPen to be at school, or to self carry while on campus. * See office for forms needed                    |
|     |    | Have Asthma?                                                                                                                                                                                                                                   | Yes _____ No _____                                                                                                                     |
|     |    | Have a Prescribed Inhaler?                                                                                                                                                                                                                     | Physician orders needed to be provided for student to self carry/self administer inhaler while on campus. *See office for forms needed |
|     |    | Diabetes?                                                                                                                                                                                                                                      | If yes, type of medication _____                                                                                                       |
|     |    | Seizures?                                                                                                                                                                                                                                      | If yes, Type _____ Frequency _____<br>Medication _____                                                                                 |
|     |    | Neurological concerns?<br>(Headaches/Migraines/etc.)                                                                                                                                                                                           | If yes, Medication/Treatment _____                                                                                                     |
|     |    | Bowel, bladder, kidney, stomach concerns?                                                                                                                                                                                                      | If yes, Medication/Treatment _____                                                                                                     |
|     |    | Cardiac (heart) concerns?                                                                                                                                                                                                                      | If yes, Medication/Treatment _____                                                                                                     |
|     |    | Orthopedic (bone/ joint) concerns?                                                                                                                                                                                                             | If yes, Medication/Treatment _____                                                                                                     |
|     |    | Diagnosed with ADD or ADHD?                                                                                                                                                                                                                    | If yes, Medication/Treatment _____                                                                                                     |
|     |    | Diagnosed with any Mental Health concerns?                                                                                                                                                                                                     | If yes, please explain _____                                                                                                           |
|     |    | Speech concerns?                                                                                                                                                                                                                               | Yes _____ No _____                                                                                                                     |
|     |    | Currently being seen by a physician for any conditions not listed?                                                                                                                                                                             | If yes, please explain _____                                                                                                           |
|     |    | Major injuries or hospitalizations?                                                                                                                                                                                                            | If yes, please explain _____                                                                                                           |
|     |    | Any recent major life change that may be affecting your child's emotional well-being?                                                                                                                                                          | If yes, please explain _____                                                                                                           |

If you have a concern about your child's development and would like to speak with any of the following personnel, please check below and describe your concern. ☐ Nurse ☐ School Psychologist ☐ Speech & Language Pathologist

Concern:

\_\_\_\_\_

\_\_\_\_\_

Parent/ Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_