2025-2026 **FAYETTEVILLE CITY SCHOOLS HEALTH HISTORY** **CONFIDENTIAL**

Part I: Student Information

Student Name_____ Grade/Teacher_____

Address_____ Email_____

Date of Birth_____ Age_____ Sex: F M Physician_____

Mother/Guardian's Name_____Home/Cell #_____Work#_____

Father/Guardians Name_____Home/Cell#_____Work#_____

Student lives with: Both Parents Mother Father Guardian

ATTEMPTS WILL BE MADE TO CONTACT A PARENT FIRST
IN CASE OF ILLNESS OR EMERGENCY

If you cannot be reached, please list emergency contacts in the order you wish for them to be contacted

1. Name_____Phone_____Relationship_____
2. Name_____Phone_____Relationship_____

Part II: Health Information

☐ **NO Significant Health Problems**

Condition

Activity Restrictions	Yes No	Hearing Impaired (hearing aids Yes No)	Yes No
Bladder/Urinary Problems	Yes No	Neurological/Birth Defects	Yes No
Cancer or history of Cancer	Yes No	Physical Disability/Impairment	Yes No
Cardiac/Heart/Blood Disease	Yes No	Skin Disorder	Yes No
Dental Problems	Yes No	Vision Problems (glasses contacts)	Yes No
G.I Disorder (Stomach)	Yes No	Headaches (including migraines)	Yes No
Other Chronic Illness or condition not listed	Yes No		

Please full explain any answers marked YES_____

_____

Has your child ever been diagnosed with a CONCUSSION? Yes No If yes, cause and date _____

Does your child have ASTHMA? Yes No If yes, medications taken_____
Does your child have ADD/ADHD? Yes No If yes, medications taken_____
Does your child have SEIZURES? Yes No If yes, describe type and meds taken_____
_____
Does your child have DIABETES? Yes No If yes, insulin, glucometer and care needed at school_____
_____
Does your child have ALLERGIES? Yes No Food Dye Bee/wasp/ant Seasonal Latex Drugs
List Drug/Food Allergies_____

Please complete reverse side

Part III: Current Medications

Does the student take any medication not listed above (prescribed and/or OTC) Please list: (include dosage,reason, and frequency)

1._____

2. _____

3._____

Is medication required during school hours? **Yes No If yes, you may obtain a medical authorization form from the school nurse.**

Please list any other factors that the school nurse, school counselor or your child's teacher(s) should know of which might affect the student's school experience_____

_____

_____

Part IV: Consent and Signature: PLEASE READ

In accordance with the "Families' Rights and Responsibilities Act", Public Chapter No. 1061, in order for a student to receive health care services by a school nurse or other person acting on behalf of the school system, a parent or guardian must provide consent that his/her student has permission to see the school nurse or other persons acting on behalf of the school system for basic health services including assessment and treatment of illness (headache, abdominal pain, vomiting, fever, etc.) injury and/or emergent care. This also includes for the student to receive basic first aid and medical care(which may include using hydrogen peroxide, antibiotic ointment, anti-itch creams, eye drops, and bandaids if necessary).

If you do not consent for your child to receive basic health care services, you will need to ensure you are able to arrive at the school within thirty(30) minutes of notification from the school for assessment and treatment of any illness or injuries of your student. If not, EMS may be called.

Because of Public Chapter No. 1061 passed by the Tennessee Legislature, Fayetteville City Schools must obtain consent of the parent or guardian to render counseling services specified in TCA 63-22-122. This includes all the duties a school counselor/social emotional counselor/social worker typically performs as part of the normal functions of the school day. These services could include meeting with the above school personnel for academic support, college and career readiness, and social and personal development. Support may be delivered individually, in a small group, or in a classroom setting.

Please initial, select answer, and sign below.

_____ I (DO DO NOT) give consent for my student to receive basic first aid and medical care at school.

_____ I (DO DO NOT) give consent for my student to receive support services that a school counselor/social emotional counselor/social worker typically performs as part of the normal functions of the school day.

_____ I (DO DO NOT) give consent for my student to receive vision and hearing screenings if needed.

_____ In the event I cannot be reached, I authorize school personnel to obtain emergency medical care for my child, including transportation by ambulance if necessary. I give consent for my child to be transported to the hospital per school personnel in the event of an emergency not requiring ambulance transportation.

Signature of Parent of Legal Guardian_____ **Date** _____