HEALTH AND WELLNESS SERVICES

Personal Health History 2025-26

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 _____