



# HEALTH HISTORY FORM

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

**MEDICAL HISTORY (If YES to any of the below, please follow-up with the school nurse)**

- YES    NO   **Does your child have any health concerns?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have restrictions to participate in any activities?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have any allergies?**  
 If yes, please list allergies: \_\_\_\_\_  
 What does the allergic reaction look like? \_\_\_\_\_
- YES    NO   **Is your child prescribed an EpiPen? For what allergies?** \_\_\_\_\_
- YES    NO   **Does your child have asthma?**  
 If yes, please describe type or triggers: \_\_\_\_\_
- YES    NO   **Does your child have diabetes?**  
 Type: \_\_\_\_\_    Self manage    Needs supervision    Uses insulin pump    Uses CGM
- YES    NO   **Does your child have a heart condition?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have a bleeding disorder?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have an orthopedic condition?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have a history of seizures or another type of neurological disorder?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have any gastrointestinal concerns or issues with eating?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have any bowel or bladder concerns?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have behavioral, emotional, or mental health concerns?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Has your child had any previous head injuries or concussions?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have a history of or being treated for any skin-related conditions (eczema, psoriasis)?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have any attention or hyperactivity disorders, such as ADHD?**  
 If yes, please describe: \_\_\_\_\_
- YES    NO   **Does your child have any vision concerns?**    GLASSES   Other: \_\_\_\_\_
- YES    NO   **Does your child have any hearing concerns?**    HEARING AID   Other: \_\_\_\_\_
- YES    NO   **Does your child currently take medications?**  
 If yes, please describe: \_\_\_\_\_

**DO ANY PRESCRIBED MEDICATIONS OR TREATMENT PLANS NEED TO BE ADMINISTERED/AVAILABLE AT SCHOOL?**

- Diabetic medications/Diabetic Care Plan     
  EpiPen/Allergy/Anaphylaxis Action Plan     
  Inhaler/ Asthma Action Plan
- Prescribed medications     
  Seizure medications/Seizure Action Plan
- Other Treatments (describe) \_\_\_\_\_



Fairbanks North Star Borough School District  
**HEALTH HISTORY FORM**

**PARENT / GUARDIAN CONSENT AND AUTHORIZATION**

**PERMISSION TO ACCESS STATE IMMUNIZATION REGISTRY**

- I CONSENT**                       **I DO NOT CONSENT**

...for the nurse to review my child's immunization information in the State of Alaska immunization registry (VacTrAK) managed by the Epidemiology Section of the Alaska Department of Health and Social Services.

The parent/guardian can remove permissions at any time by submitting your request in writing.

**PERMISSION TO ADMINISTER NONPRESCRIPTION (OTC) MEDICATION AT SCHOOL**

With written parent/guardian consent, over-the-counter (OTC) medications listed on the standing orders from the district medical director may be administered to students. Administration will occur only after assessment by a registered school nurse or RN Manager, who determines the medication is necessary to support the student's ability to participate in the school day. **Check all that may be administered by the Health Office and/or designated trained unlicensed staff:**

- Tylenol (acetaminophen)                       Zyrtec (cetirizine)  
 Motrin/Advil (ibuprofen)                       TUMS (antacid)

**PARENT ACKNOWLEDGEMENT**

The FNSBSD Health Office staff must be notified if any medications need to be given during the school day. State law requires written authorization from a healthcare provider and parent before any prescription medication can be given at school, including self-carry medication. All types of medication require an authorization/consent form AND the medication(s) must be delivered to the school by a parent/guardian in a pharmacy labeled container.

Release of Information: The disclosure of health information within the school is limited to information. Necessary to ensure the student's health and educational interests are met. Your signature below gives permission for school staff to be informed of precautions and procedures necessary to protect your child while at school.

**My signature below is acknowledgement that the information provided is current and correct. I have reviewed the health history form and understand that it is my responsibility to notify the school when my child's health information has changed. I agree to provide any medications or supplies needed for care of my child in school if needed. I will notify the school if my consent for the above items needs to be updated or changed, per my preference.**

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

**MEDICAL PROVIDER / PEDIATRIC GROUP:** \_\_\_\_\_ Phone \_\_\_\_\_

**OTHER PROVIDER:** \_\_\_\_\_ Phone \_\_\_\_\_