

# Student Medical History



Student's Name: \_\_\_\_\_ School: \_\_\_\_\_

Complete the following checklist by indicating any of the following student conditions.

This child has no health needs.

### Allergies

<input type="checkbox"/>	Environment	Please list:
<input type="checkbox"/>	Food	Please list:
<input type="checkbox"/>	Insect/Bees	Please list:
<input type="checkbox"/>	Medications	Please list:
<input type="checkbox"/>	Other	Please list:

### Health Conditions

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bone/Joint/Muscular Disorder	<input type="checkbox"/> Migraines/Headaches
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Obsessive Compulsive Disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Convulsion/Epilepsy	<input type="checkbox"/> Oppositional Defiant Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Reflux (gastroesophageal)
<input type="checkbox"/> Asthma Mild <input type="checkbox"/> Asthma Moderate <input type="checkbox"/> Asthma Severe	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Autism/Aspergers	<input type="checkbox"/> Digestive/Bowel Problems	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Bi-Polar	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Tourettes (Tics)
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Traumatic Brain Injury

### Current Medications

*Please provide information in boxes*

Med #1:	Dosage:	Condition:
Med #2:	Dosage:	Condition:
Med #3:	Dosage:	Condition:

### Vision

### Hearing

<input type="checkbox"/>	Glasses/Contacts	<input type="checkbox"/>	Hearing Aids
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<input type="checkbox"/>	Vision Concerns	<input type="checkbox"/>	Hearing Problems
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**Healthcare provider information on file**

*Please provide information in boxes*

Physician	
Hospital	

<input type="checkbox"/>	I acknowledge that the above information relating to the health of my child is current	Signature:  Date:
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**Indicate the medication(s) that your child may receive:**

- Acetaminophen
- Ibuprofen
- Benadryl

I give permission for my child to receive ACETAMINOPHEN, IBUPROFEN, and/or BENADRYL (as indicated) when deemed necessary and delegated by the Registered/School Nurse. Dosage will be calculated based on my child's current weight. I understand that a generic equivalent may be used. I understand that the above medications I have checked will be administered by the Registered/School Nurse.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian Signature)

**Consent for Treatment of Minor Dependents**

Student's Full Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

If unable to reach responsible party for dependent child, \_\_\_\_\_  
(Name of Student)

You have my consent to call \_\_\_\_\_ at \_\_\_\_\_  
(Physician's Name) (Phone #)

and/or send to \_\_\_\_\_ by ambulance if situation warrants.  
(Hospital name)

I further give my consent to the above physician and/or hospital to care for the dependent child at their discretion in the best interest of the child.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian Signature)