RIVERSIDE UNIFIED SCHOOL DISTRICT
Health Services
5700 Arlington Avenue, Riverside, CA 92504

CONFIDENTIAL HEALTH HISTORY FORM

School________________ **Grade**_______

Student Name ___________________________ **Birthdate** __________**Age**____☐ **Male** ☐**Female**

List all health issues your child has:____
____

Does your child take medication on a routine basis? ☐ Yes ☐ No ☐ During school hours? ☐Yes ☐ No If yes,

Please list the name of the medication and the condition it is used for below:

Medication/Condition_____________________________ Medication/Condition____________________________________

Medication/Condition_____________________________ Medication/Condition ____________________________________

If your child must take medication during the school day, complete the Medication Administration parent/physician authorization form and return to the school office (one form for each medication).

*****_**Medication must be brought to the school by a parent**_*****

Check ☑ the box and explain if your child has a history of or now has the following conditions or concerns.

☐ **Asthma (Additional medication forms needed for inhaler on campus)**
- Inhaler needed on campus? ☐ **Yes** ☐ **No**

☐ **Diabetes** ☐ **Type I** ☐ **Type II**
- *If Diabetes checked, speak to Health Assistant or District Nurse about additional forms needed and policy and procedures.*

☐ **Heart/Cardiac Condition** (please request the cardiac/ heart history form)______________________

☐ **Seizure (please request the seizure history form)**
- ☐ Date of last seizure _____________________
- ☐ Type_____________________________________
- ☐ Currently takes medication for seizures

____

☐ **Allergies/list reaction**
- ☐ Bees
- ☐ Foods- Please request the allergy history form and the meals accommodation form (must be filled out by medical provider)

____
____
- ☐ Medication ______________________________
- ☐ Other __________________________________

☐ **Lactose Intolerance** (please complete milk substitution or meals accommodation form)

☐ **Physical Limitations** ___________________________
- ☐ **Special Equipment needed at home**
- ☐ **Special Equipment needed at school**

Describe equipment?_____________________________
____

Is your child *currently* under a doctor's care for any of the above? ☐ **Yes** ☐ **No**

If yes: Doctor's name ____**Phone** ______________________**Fax**___________

Address____

☐ *My child **does not** have any health issues at this time.*

☐ **I hereby give permission to share information pertaining to the health of my child with school staff who need to know.**

Parent/Guardian Signature ____ ***Date*** ____________________________

For Office Use Only:
☐ Original to Cum ☐ Sent to District Nurse ☐ *Health Assistant* ☐ Teacher

CONFIDENTIAL