BENTONVILLE SCHOOLS

Student Health History

Student Name: _____ Date of Birth: _____ Grade: ____ Teacher: _____

Parent/Guardian Name (Print):_____Phone:_____

Parent/Guardian Name (Print):_____Phone:_____

Emergency Contact: _____ Phone #: _____

Primary Email: _____ Secondary Email: _____

Doctor: _____ **Hospital**: _____ **Insurance**: Private____ Medicaid/AR Kids: ___

Medically Diagnosed Conditions	Current	Past (Year)	Never	Medically Diagnosed Conditions	Current	Past (Year)	Never
ADD/ADHD				Heart Condition / Heart Surgeries			
***Asthma**				High/low blood pressure – blood issues			
Balance issues; leg braces, wheelchair, etc.				Intestinal Issue/Constipation/Encopresis			
***Diabetes** or Sugar in urine				Loss of family, divorce/separation, move			
Dizziness or Fainting spells				Seasonal Allergies, hay fever			
Dyslexia (include medical documentation)				**Severe behavioral issues**			
Eczema, Skin disease				***Severe Allergies (Requires Epi-Pen)**			
***Epileptic** seizures / convulsions				Severe or Chronic Abdominal Pain			
Eye trouble				Severe Head injury / Concussion			
Frequent ear infections / Ear tubes				Tumor, Growth, or **Cancer**			
Frequent or Painful Urination				Wears Glasses/Contact lenses			
Frequent, Severe Headache				Wets or Soils Pants day or night			
Hearing loss / Hearing aids				Worry, anxiety/depression, sleep issues			

***It is mandatory, students with Asthma, Diabetes, Anaphylaxis, Seizures, etc., have an updated health care plan on file.**

Explain health conditions or surgeries: _____

_____

Has your child received recent immunizations: Y____ N ____ Filed for Arkansas Immunization Exemption? Date: _____ **Give copy to RN**

List current medications your child takes regularly/daily <u>at home or at school</u>:

<u>Medication</u>	**<u>Dosage & Frequency</u>**	**<u>Purpose</u>**	**<u>Side Effects</u>**

List any Allergies to *foods or medications (Prescription or over the counter):

Allergy: _____ Reaction: _____ *Recommended Medication: Benadryl: ____ Epi-Pen:____

Allergy: _____ Reaction: _____ *Recommended Medication: Benadryl: ____ Epi-Pen:____

Check SCREENINGS you <u>DO NOT</u> want for your child: ____BMI (K,1,2,4,6,8,10) ____Scoliosis (Girls -6&8 and Boys-8)

This consent must be signed for school to adhere to doctor-ordered care plans and for student to receive over the counter medications. Over the counter medications and emergency Epinephrine and Narcan are available to your child per nurse's assessment. Dosages are based on label instructions and are approved by Dr. Curtis Hedberg. **If your child needs any scheduled prescription or non-precription medications during the school day, a parent or guardian MUST bring medication to the nurse in the original container, <u>ALONG WITH</u> written prescribed orders by an Arkansas Licensed Healthcare Professional.** I hereby authorize any/all medical providers of the Student, for which I am the parent or legal guardian, to confer with and/or release information and records regarding said Student's health care to any representative of the Bentonville School District requesting such information and records. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment necessary for the well-being of my child.

Parent/Guardian Signature: _____ **Date:** _____

****Office use only****

504:_____ **IHP:** _____ **Processed by:** _____**Date:**_____