

**ROBERTSON COUNTY SCHOOL NURSING SERVICES**

**2026-2027 Student Health History Form**

|                                      |                                |                        |
|--------------------------------------|--------------------------------|------------------------|
| <b>Student Name:</b>                 | <b>Grade:</b>                  | <b>DOB:</b>            |
| <b>Address:</b>                      |                                |                        |
| <b>Parent Name (Please Print):</b>   |                                | <b>Parent Phone #:</b> |
| <b>Emergency Contact Information</b> |                                |                        |
| <b>Emergency Contact Name</b>        | <b>Relationship to Student</b> | <b>Phone Number</b>    |
| 1.)                                  |                                |                        |
| 2.)                                  |                                |                        |
| 3.)                                  |                                |                        |

1. Has the student been diagnosed with any of these medical conditions? YES NO  
Please circle:      Asthma                      Diabetes                      Seizures  
Please list any other medical condition or information: \_\_\_\_\_  
Has the student been prescribed Asthma medication? YES NO  
Has the student been prescribed seizure medication? YES NO  
• If medication will be required at school, the parent/guardian must provide the medication, doctor's order and parental consent.  
• Please contact the school nurse for the correct forms.  
Please list type of seizures: \_\_\_\_\_  
Date of last seizure: \_\_\_\_\_
2. Does the student have any significant allergies to foods or insects? YES NO  
Please list the specific allergy and reaction if exposed to their allergen: \_\_\_\_\_  
\_\_\_\_\_  
Does the student have an Epi-pen prescribed? YES NO  
• If an Epi-pen will be required at school, the parent/guardian must provide the Epi-pen, doctor's order and parental consent.  
• Please contact the school nurse for the correct forms. Food allergies require a doctor's order on file.  
• Please see the school nurse for the correct documentation.
3. Is the student currently taking medications? YES NO  
Name of medications: \_\_\_\_\_ When taken: \_\_\_\_\_  
• If medication will be required at school, the parent/guardian must provide the medication, doctor's order and parental consent.  
• Please contact the school nurse for the correct forms.
4. Has the student been recently hospitalized or been under the care of a physician? YES NO  
Please describe: \_\_\_\_\_  
Date Occurred: \_\_\_\_\_ Type of treatment received: \_\_\_\_\_
5. Has the student been diagnosed with any behavioral/emotional issues? YES NO  
Please explain: \_\_\_\_\_
6. Does the student have any hearing problems or wear hearing aids? YES NO  
Please explain: \_\_\_\_\_
7. Is there any reason the student is unable to participate in Physical Education class? YES NO  
• If yes, please explain: \_\_\_\_\_

Name of student's doctor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**\*\* Except for emergency medications (Inhalers, Epi-pens, Glucagon) which are accompanied by a doctor's order, BOARD POLICY DOES NOT ALLOW STUDENTS TO CARRY ANY MEDICATION WITH THEM AT SCHOOL. Both prescription and over the counter medications require specific documentation to be on file with the nurse. If your child requires medication at school, please contact the school nurse for the appropriate documentation.**

**\*\* Parents are responsible for notifying the school nurse of any health developments that occur throughout the school year.**

**\*\* Health Consent: Your signature on this document gives consent for the school nurse or other persons acting on behalf of the school system to provide basic health services including treatment of illness, injury and/ or other non-emergent care. Your signature also permits the school nurse to share your child's health information with school staff and to discuss your child's care with healthcare providers, on a need-to-know-basis, to best protect your child in the school environment.**

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_