

Missoula County Public Schools
CONFIDENTIAL Student Health History

Full Student Name: _____ Grade: _____

School: _____ Date of birth: _____

School staff are informed of health conditions and treatments on a need-to-know basis in order to keep students safe. Information provided may be used to treat the student during class, activities, and health office visits. The information provided will also help us understand learning and health needs. **Note:** Food preferences, lifestyle/religious diets are addressed between the parent/guardian and the student. It is not the school's responsibility to monitor for preferences.

Please indicate YES or NO if your student has or has had the below conditions. A YES answer requires additional details. Conditions with an asterisk* indicate additional forms or information may be required. Please use blue or black ink.

Condition	Yes	No	Details	Condition	Yes	No	Details
ADHD, ADD	☐	☐		Frequent/recurring	☐	☐	
Autism	☐	☐		Dizziness	☐	☐	
Allergy- *Life-threatening	☐	☐		Headache	☐	☐	
*Epi Pen prescribed	☐	☐		Infections	☐	☐	
Allergies-other	☐	☐		Migraine	☐	☐	
Asthma	☐	☐		Nose bleeds	☐	☐	
*Inhaler at school	☐	☐		Pain	☐	☐	
Anemia	☐	☐		Stomach ache/nausea	☐	☐	
Bleeding disorder	☐	☐		Head injury/concussion dates:	☐	☐	
Arthritis	☐	☐		Heart Disease/condition	☐	☐	
Behavioral/emotional	☐	☐		Hospitalizations	☐	☐	
Bladder/bowel/urinary	☐	☐		Immune system issues	☐	☐	
*Ostomy	☐	☐		Lung/breathing conditions	☐	☐	
Bone/muscle/joint problems	☐	☐		Mental health /psychiatric	☐	☐	
Fractures/broken bones	☐	☐		Mobility/assistive device	☐	☐	
Developmental delays	☐	☐		Neurologic/neuromuscular	☐	☐	
*Diabetes	☐	☐		*Seizures (indicate type)	☐	☐	
Ear/hearing	☐	☐		Rescue meds	☐	☐	
Wears hearing aid(s)	☐	☐		Daily seizure meds	☐	☐	
Sign language	☐	☐		Sleep	☐	☐	
Eye/vision/color vision	☐	☐		Apnea	☐	☐	
Wears glasses/contacts	☐	☐		Snoring	☐	☐	
Color blind/deficient	☐	☐		Skin conditions/rash	☐	☐	
*Feeding Tube	☐	☐		Speech/communication	☐	☐	
*Food intolerances	☐	☐		Surgeries (Date/type)	☐	☐	
List food & reaction	☐	☐		Other:	☐	☐	
ADDITIONAL INFORMATION:							

***Medications & treatments**-list all meds, treatments, etc. **Please attach or enter additional information above, if needed.**

1. Treatment/med _____ Times needed _____ For _____
2. Treatment/med _____ Times needed _____ For _____
3. Treatment/med _____ Times needed _____ For _____
2. Treatment/med _____ Times needed _____ For _____

In case of an accident or serious illness, the school will provide first aid and contact a parent/guardian to obtain further medical attention. The school may notify emergency services if deemed necessary. If appropriate and the school is unable to contact the parent/guardian, the school may contact the medical provider listed below and follow his/her instructions

Health care provider(s) _____ Phone(s) _____

Parent/guardian signature _____ Date _____