STUDENT HEALTH HISTORY

Dear parent/guardian: Please complete this form, sign, and return to the school office.

Student Name: _____ Date of Birth: _____ School: _____

Homeroom teacher: _____ Grade: _____ School year: _____

Is your child on any prescription medications that will need to be given at school? Yes: ☐ No: ☐
If **YES,** a medication form must be completed and signed by the parent/guardian. **MEDICATION AND ACTION PLANS MUST BE UPDATED YEARLY.**

Endocrine disorders:
☐ Diabetes:
☐ Requires Insulin
☐ Insulin not required
☐ Hormonal
☐ Thyroid
☐ Other_____
_____
☐ Medication: ___
_____

Lungs/Respiratory disorders:
☐ Asthma
☐ Medication: ___
_____
☐ Inhaler/nebulizer used last 2 years.
☐ Tracheostomy
☐ Other: _____
_____

Allergies:
☐ Life threatening
☐ ☐ Bees
☐ ☐ Food: List
_____
_____
☐ Latex
☐ Need Epi- pen
☐ Non- Life Threatening:
☐ seasonal
☐ Other _____

Cancer:
Type: _____
Date Diagnosed: _____
☐ Indwelling port

Blood Disorder:
☐ Anemia
☐ Hemophilia
☐ Sickle cell disease
Trait: _____
☐ Thallassemia
☐ Other: _____
_____

Heart Condition:
☐ High blood pressure
☐ Irregular heart rhythm
☐ Medication:____
_____
☐ Other: _____
_____

Bone/Joint:
☐ Arthritis
☐ Lupus
☐ Uses crutches, braces, walker, wheelchair.
☐ Other: _____
_____

Kidney/Bladder:
☐ Catheter
☐ Disposable briefs
☐ Urinary incontinence
☐ Other:_____
_____

Gastrointestinal:
☐ IBS/Crohn's Disease
☐ Feeding tube
☐ Other: _____
_____

Ears:
☐ Hearing impaired
☐ Cochlear implants
☐ Wears hearing aids
☐ Other: _____
_____

Eyes:
☐ Prosthetic eye/s
☐ Vision impaired
☐ contacts
☐ Glasses
☐ Other: _____
_____

Skin:

☐ Eczema
☐ Psoriasis
☐ Other: _____

_____

Behavioral/Emotional:

☐ Anxiety
☐ Bipolar disorder
☐ Depression
☐ Eating Disorder
☐ OCD/ODD/PTSD
☐ Other: _____

_____

Muscular:

☐ Muscular Dystrophy
☐ Multiple sclerosis
☐ Other: _____

_____

Food Modifications:

_____
_____
_____
_____

Genetic/Chromosomal:

_____
_____
_____
_____

Other: _____
_____
_____
_____

Has your child ever stopped breathing? ☐ Yes ☐ No

Has your child ever needed CPR? ☐ Yes ☐ No

Has your child ever needed the Heimlich Maneuver (emergency response) for choking? ☐ Yes ☐ No

Has your child ever been hospitalized for any condition(s) checked? ☐ Yes ☐ No

If yes, list condition and dates:

_____
_____
_____
_____

My child does not have any health conditions: ☐

Parent Name: _____

(Please Print)

Parent Signature: _____ **Date:** _____

Please write additional health information beside "Other conditions" above.