Updated 2021-03-16

Student Health History

Student health information within the school is limited to the information necessary to serve the student's educational and health interests.

Student Name _____ DOB _____ Date _____

☐ yes ☐ no My child has no health problems which would affect his/her school day

My child's health needs include the conditions checked below

☐ yes ☐ no Allergies, please list allergy and what happens: _____

☐ yes ☐ no Is an EpiPen* prescribed – if yes, what for _____

☐ yes ☐ no Asthma with inhaler* use, if so, how often _____

☐ yes ☐ no Diabetes any medication* (s) used _____

Any special procedures followed during the school day? _____

☐ yes ☐ no Hearing problems, please describe: _____

☐ yes ☐ no Vision problems ☐ wears glasses ☐ wears contacts ☐ other _____

☐ yes ☐ no Diagnosed learning disabilities, list any medication(s) _____

Will medication* be needed during school? ☐ yes ☐ no

☐ yes ☐ no Bone/joint problems or fractures, list issue(s) _____

Brace worn? ☐ yes ☐ no

☐ yes ☐ no Seizure disorder, list type _____ Date of last seizure _____

Medication*(s) taken _____

☐ yes ☐ no Episodes of loss of consciousness Date last occurred? _____

Medication(s) taken _____

Any special treatment? _____

Emotional concerns, please list: _____

Please list any other medical problems or illnesses.

Doctor's Name _____ Phone _____

Does your child see a specialist ☐ yes ☐ no Name/Type _____

Reason _____ Phone _____

***Parent must complete the school's Medication Approval Form and have signed by the student's doctor for any prescription or OTC medication to be taken at school.**

Health History Informed Consent

Your signature below gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans.

Parent/Guardian _____ Date _____

Phone Number _____