

Student Name _____ Grade _____ Birth date _____

Parent/Guardian Name _____ Parent/Guardian Email _____

Home Phone _____ Work/Cell Phone _____

Medical History:

Has your student ever had a serious accident, operation, or illness? (nature and approx. date) _____

Please check any **HEALTHCARE PROVIDER DIAGNOSED** health concerns that your student has. If your student does not have any health concerns, simply check the box that says "No Health Concerns at this time".

No Health Concerns at this time

ALLERGIES

Bee or insect allergy
Reaction Mild Severe/Life Threatening
Symptoms _____
Treatment _____

Seasonal allergies

Food allergy

List foods _____

Reaction Mild Severe/Life Threatening
Symptoms _____
Treatment _____

Latex allergy

Drug allergy _____

*Has EpiPen

NEUROLOGICAL

Seizure Disorder Type: _____

ADD ADHD

Autism Spectrum Disorder

Headaches Migraines

Other: _____

DIGESTION/ELIMINATION

Bowel control problems

Irritable Bowel Syndrome

Bladder incontinence

Other: _____

DIABETES

Type I Type II

VISION/HEARING

Vision deficit Glasses/Contacts

Hearing deficit Hearing Aid

CARDIOVASCULAR

Heart Murmur Arrhythmia _____

Cardiac Disorder _____

Heart Birth Defect

Other: _____

RESPIRATORY

Asthma – mild Intermittent symptoms, infrequently uses rescue inhaler, no interference with normal activity

Asthma – moderate Persistent symptoms, uses rescue inhaler, some activity limitation

Asthma – severe Daily symptoms, uses rescue inhaler several times a day, normal activities extremely limited

Has Inhaler at? *School Home

Triggers of asthma

Exercise Dust Pollen Respiratory illness

Change in temperature Other _____

Other: _____

MUSCULOSKELETAL/SKIN

Cerebral Palsy

Other Musculoskeletal condition _____

Other Skin conditions: _____

BEHAVIORAL HEALTH

Obsessive Compulsive Disorder

Oppositional Defiant Disorder

Bipolar Disorder

Depression

Other: _____

CONGENITAL

Down Syndrome

Other: _____

HEMATOLOGICAL

Hemophiliac Sickle Cell Other: _____

Medication:

Medication student takes daily **at home** (list medications): _____

Medication **at school** (list medications): _____

***If medication is needed at school, complete and return an "Authorization for Medication at School" form. Health care provider AND parent/guardian signatures are required. Form can be obtained from school nurse, office, or district website.**

I authorize the disclosure of health information on this form to be shared with the school nurse or other staff responsible for my student during the school day.

Parent/Guardian Signature: _____ Date: _____