

HEALTH HISTORY & MEDICAL INFORMATION

STUDENT NAME: _____ **DOB** _____ **GRADE** _____

ALLERGIES

Bee Sting: *needs medication at school and medical follow-up

Food Allergy: Name of Food(s) _____

*needs medication at school and medical follow-up mild reaction but needs to avoid ingestion

Describe reaction _____

Other allergies: _____

ASTHMA

*needs medication at school *self-administers medication as needed *no medication needed at school

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

*needs Medication at school taking medication at home only diagnosed / no medication given

DIABETES

*Insulin dependent/needs school program set up *Self-manages snacks, diet, testing, coverage

SEIZURES

*needs Medication at school takes medication at home history of seizure / not currently on meds

HEARING CONCERNS (please explain) _____

VISION CONCERNS (please explain) _____

PHYSICAL RESTRICTIONS

*uses mobility aide (wheelchair, walker, crutches, etc.)

*restricted because of _____

*must avoid this/these activities _____

(doctor letter required for some Physical Education adaptations)

OTHER MEDICATIONS: at home at school _____

What **operations, serious accidents** or **serious illnesses** has he/she had? _____

In the following list of diseases, CHECK those your child has had and give the year he/she had them, if known.

| | <u>CHECK</u> | <u>YEAR</u> | | <u>CHECK</u> | <u>YEAR</u> |
|---------------------|--------------|-------------|-------------------------|--------------|-------------|
| CHICKENPOX | _____ | _____ | ASTHMA | _____ | _____ |
| MEASLES (RUBELLA) | _____ | _____ | ECZEMA | _____ | _____ |
| RUBELLA (3-DAY) | _____ | _____ | KIDNEY PROBLEMS | _____ | _____ |
| SCARLET FEVER | _____ | _____ | RHEUMATIC FEVER | _____ | _____ |
| WHOOPING COUGH | _____ | _____ | EPILEPSY/SEIZURES | _____ | _____ |
| MUMPS | _____ | _____ | CONVULSIONS | _____ | _____ |
| FREQUENT COLDS | _____ | _____ | DIABETES | _____ | _____ |
| EAR INFECTIONS | _____ | _____ | HEART DISEASE | _____ | _____ |
| SINUSITIS | _____ | _____ | CONGENITAL CONDITION | _____ | _____ |
| ORTHOPEdic PROBLEMS | _____ | _____ | OTHER (Please describe) | _____ | _____ |
| ALLERGIES/HAYFEVER | _____ | _____ | | | |

IMMUNIZATION RECORDS: Documentation by a physician or clinic indicating dates of immunization is required. Your school will need a photocopy of your child's immunization record before he/she will be allowed to attend school.

IN AN EMERGENCY, I AUTHORIZE MEDICAL DENTAL CARE:

HOSPITAL PREFERENCE: DEACONESS _____ ST. VINCENTS _____ EITHER _____

CHILD'S DOCTOR _____ PHONE # _____

CHILD'S DENTIST _____ PHONE # _____

PARENT SIGNATURE _____ DATE _____

Note: All starred (*) items will require notification of the school nurse. If medication is needed, the parent must complete a medication authorization form before the first dose of medication can be given at school.

☆ This health concerns information may be shared with school personnel as necessary to benefit the health and safety of your student and others. Please keep this information up to date. ☆