STUDENT HEALTH HISTORY
School Year 2020-2021

Please check all conditions that apply. If your child has No Chronic Health Conditions, skip to the final box and sign below. All information given on this form will be shared with appropriate school staff on a "need to know" basis in order to provide for the health and safety of your student.

Student Last Name: _____

First Name: _____

_____

DOB **Grade** **School**

LIFE THREATENING HEALTH CONDITIONS

RG ☐ **SEVERE Asthma (see below if not severe)**
EG ☐ **SEVERE Allergy (requiring Epipen)**
Allergy to:

EK ☐ **Diabetes Type 1 (insulin dependent)**
NP ☐ **Seizures**
C_ ☐ **Heart condition:**
BB ☐ **Hemophilia**

State Law requires that students with life threatening conditions such as anaphylaxis, asthma, seizure, cardiac, hemophilia or diabetes have a parent meeting with the School Nurse & care plan completed prior to the first day of school.

Please contact the building nurse as soon as possible to ensure that paperwork is complete, which allows your student to attend school.

Other Conditions

NB ☐ ADHD/ADD Diagnosed by:
ED ☐ Allergy - Food:
EE ☐ Allergy - Insect:
EM ☐ Allergy - Medication:
EB ☐ Allergy - Seasonal:
E_ ☐ Allergy - Animal:
PA ☐ Anxiety
RG ☐ Asthma currently treated (not severe) using inhaler
RH ☐ Asthma past history no longer using inhaler
NC ☐ Autism Spectrum Disorder
B_ ☐ Blood condition:
GA ☐ Celiac Disease
NE ☐ Cerebral Palsy
YA ☐ Chronic Ear Infections
UB ☐ Chronic Urinary Tract Infections
NU ☐ Concussion history/Traumatic Brain Injury
EJ ☐ Cystic Fibrosis

PC ☐ Depression
NF ☐ Developmental Disability
EL ☐ Diabetes Type 2
EN ☐ Eating Disorder
GH ☐ GERD/Acid Reflux
N_ ☐ Headaches OR ☐ Migraines
GK ☐ Irritable Bowel OR ☐ Crohns
M_ ☐ Musculoskeletal Disorder:
RE ☐ Reactive Airway Disease
EU ☐ Thyroid condition:

Other pertinent medical history (hospitalizations, injuries, other diagnoses/conditions not listed):

List ALL Current Medications (Circle those that will be taken at school):

Please note: State law requires written permission from health care provider and parent before any medications (prescription AND over the counter) can be carried and/or taken at school. Forms available online and in each school office.

My student wears: ☐ Glasses YF ☐ Contact Lenses YF ☐ Hearing Aids YB ☐ Other:

☐ **My student has NO CHRONIC HEALTH CONDITIONS at this time.**

If parent/guardian or authorized emergency contact cannot be reached at the time of a medical emergency, and if immediate care is urgent in the judgement of school authorities, I authorize and direct school authorities to send the student to the nearest and most appropriate healthcare facility. I understand that I will assume full responsibility for the payment of any services rendered.

Date:	**Signature:**	**Relationship:**	**Phone:**

Revised 1/2020