District 4 Student Health History

Student Name:_____ **Today's Date:** _____

Grade: _____ **Gender:** _____ **DOB:** _____/_____/_____

List **all** medications student takes at home or at school: _____

_____

Check all that apply.

__ Blood Issues (anemia, sickle cell, hemophilia)

__ Eating Disorders

__ Hay Fever /Seasonal Allergies

__ Kidney Problems

__ Migraine Headaches

__ Skeletal/Muscular Problems

__ Special diet

__ Ear Problems __tubes? __hearing aid?

__ Eye Problems __ glasses? __ contacts?

__ High Blood Pressure

__ Low Blood Sugar

__ Nervous Stomach

__ Skin Problems

__ Speech Problems

Please see the school nurse for any item marked in this list.

__ Asthma diagnosis — Inhaler used on a regular basis? ___ Sports induced?___

__ Food allergies — List food items: _____

__ Seizures — Type _____ Date last seizure_____

__ Allergies, severe — List specific emergency allergies: _____

__ Insect sting sensitivity — Does student have or require EPI pen? ___

__ Diabetes — Sugar check at school? ___ Injections? ___ Pump? ___

Provide additional information and/or list any other medical issues: _____

_____

This form is maintained in your child's confidential health record so that in an emergency, school officials may have critical information to provide emergency care. In the event parents cannot be located, school officials will take appropriate action deemed necessary for the safety of your child.

Parent Signature: _____ ***Date:*** _____

Please note: All medications taken at school whether prescription or over-the-counter medicines must be stored in the Nurse Office. For ANY medication to be administered at school, there must be a signed, medicine-specific parent consent form AND a written doctor's order on file. Forms are available in the Nurse Office or on the school web page.