Harris County School System Health History Form

Student's Name: _____

CONTACTS	**Parent/Guardian** **First Contact**	**Parent/Guardian** **Second Contact**	**Emergency Contact** Other than guardian
	Name	Name	Name
	Home #	Home #	Phone #
	Cell#	Cell#	**Physician's Name:**
	Work #	Work #	**Physician's Number**:

Important: Check the right of the column if your child *HAS* any of the following:

HEALTH HISTORY								
	ADHD			Dizziness			Neurological Disease	
	Anemia			Ear Infections			Neuromuscular Disease	
	Arthritis			Eating Disorder			Premature Birth	
	Asthma			G I Disorder			Physical Handicaps	
	Birth Defects			Frequent Headaches			Respiratory Disease	
	Bladder Problems			Head Injury History			Scoliosis	
	Blood Disorder			Hearing Disorder			Seizures	
	Bone Disorder			Heart Disorder			Sickle Cell Disease	
	Bone Fractures			Heart Murmur			Sinus Problem	
	Bronchitis			High Blood Pressure			Skin Condition	
	Cancer			Immune Disease			Sleep Disorder	
	Chronic Pain			Inherited Disease			Swallowing Difficulty	
	Cystic Fibrosis			Kidney Disease			Thyroid Disorder	
	Concussion			Liver Disease			Tuberculois	
	Diabetes *****			Mental Illness			Vision Disorder	

If you checked a box, please explain: _____

_____

Hospitalizations, surgeries, etc.: _____

Does your child have any condition that would limit physical education activities: _____

_____

ALLERGIES	MEDICATIONS	DEVICES
Please describe reaction below: ___ **No Known Allergies** ___ Drug Allergy ___ Food Allergy ___ Other (chemicals, bee stings) List allergens and **DESCRIBE REACTION** _____ _____ _____ _____	**List ALL medications currently taking.** _____ _____ _____ Emergency Medications: Home/School Inhaler_____/_____ Nebulizer _____/_____ Epi-Pen _____/_____ Glucagon _____/_____ Diastat _____/_____	Medical/Assistive at school or home ___ Brace ___Braces ___ Contacts ___ Glasses ___ Crutches ___ Hearing Aid ___ Helmet ___ Insulin Pump ___ Port ___ Prostheses ___ Walker ___Wheelchair ___ Other _____

IMPORTANT: ALL medications should be brought the first day of school with Prescription Medication form signed and completed. *** Diabetes Medical Management Plan (DMMP) required by state law annually.**

In case of serious illness/injury the school will render first aid while contacting parent/guardian. If the school is unable to contact parent/guardian, and the situation is serious, the school will call 911 for the emergency medical unit to transport the child to the nearest ER. Fees for transportation will be the responsibility of the parent/guardian.