

STUDENT HEALTH HISTORY UPDATE

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

Date _____ Parent/Guardian's Signature _____

Student _____ DOB: _____ Grade _____ Teacher _____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

- | | | | |
|---|--|--|----------------------------------|
| 1. <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bone/Spine | <input type="checkbox"/> Heart | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Infections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Emotional | <input type="checkbox"/> Physical Disability | |
| <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Hearing | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> OTHER _____ | | | |

Comments: _____

2. Does your child have allergies to medicine, food, latex or insect bites?
NO YES To What _____ What happens? _____
Treatment _____

3. Has your child had any illnesses since school last ended?
NO YES Type of illness, with date(s) _____

4. Has your child had surgery since school last ended?
NO YES Type of surgery, with date(s) _____

5. Has your child received any immunizations since school last ended?
NO YES List immunizations, with dates _____

6. Is your child being treated or evaluated for any health conditions?
NO YES List condition _____

7. Is your child on any medication or treatment?
NO YES Name of medication and/or treatment _____
Does your child need medicine during school hours?
NO YES ****If yes, please contact the school nurse to make arrangements.***

8. Has your child ever been examined by an eye doctor?
NO YES Date of last exam _____
NO YES Glasses Prescribed _____
If your child wears glasses or contact lenses, when was the prescription last changed _____

9. What is the name of your child's dentist? _____
What is the date of his/her last dental exam? _____

10. What is the name of your child's primary healthcare provider? _____
What is the date of his/her last physical exam? _____

11. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year?
NO YES ****If yes, please contact your School Nurse or School Counselor.***

12. Have you, your child or anyone in your household tested positive for COVID-19?
NO YES ****If yes, please contact the school nurse.***