

**ESSEX COMMUNITY SCHOOL DISTRICT  
2023-2024 ANNUAL HEALTH HISTORY**

***Dear Parent/Guardian: Your child's success in school depends to a great extent on his/her physical well-being. In order to better care for your child here at school, we request that you complete this form each year to update your child's health records. Thank you!***

**Student Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Grade** \_\_\_\_\_

Present and/or Past Health Problems or Illness: Has a doctor told you that your child has any of the following conditions?

Allergies: \_\_\_\_\_

If yes, does the student require the use of an EpiPen? \_\_\_\_\_

ADD/ADHD \_\_\_\_\_ Mental Health Problems \_\_\_\_\_

Asthma \_\_\_\_\_ (if yes, Asthma Action Plan is required) Vision Problems \_\_\_\_\_

Bone/Joint/Muscle concerns \_\_\_\_\_ Seizures \_\_\_\_\_

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Type I or II

Dental Problems \_\_\_\_\_ Serious illness in last year \_\_\_\_\_

Dizziness/Fainting \_\_\_\_\_ Serious accident in last year \_\_\_\_\_

Head injury \_\_\_\_\_ Surgeries \_\_\_\_\_

Hearing Difficulty \_\_\_\_\_ Heart Problems \_\_\_\_\_

Does your child take any medications regularly? If yes, please include the name, frequency, and reason for use.

\_\_\_\_\_  
If your child needs to take any medications during school hours, a permission form will need to be filled out for each medication.

Does your child have any restrictions? \_\_\_\_\_  
**(Activity restrictions greater than one day need a written note from a physician).**

Does your child have any assistive devices? (glasses, hearing aids, etc.) \_\_\_\_\_

Does your child have any emotional, social, or other conditions that may his/her school performance? \_\_\_\_\_

Is your child covered by health insurance? \_\_\_\_\_ Dental Insurance? \_\_\_\_\_

Do you give the school nurse permission to contact your family doctor/dentist? Yes No

Family Doctor Name \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist Name \_\_\_\_\_ Phone # \_\_\_\_\_

Hospital Preference \_\_\_\_\_

**If a hospital emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand that I am responsible for updating this information as needed. This information is confidential but may be shared with the appropriate school personnel as necessary.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_