

Student Health History Form

Dear Parent or Guardian,

To ensure proper medical treatment at school we rely on you to keep the school informed of new developments regarding your child's health. Please complete the **front and back** of this form and provide **signatures** where requested so we have current health information in your child's file for their attendance in school each year.

Student's Name: _____ Date of Birth: _____

Please circle:

- | | | |
|--|-----|----|
| 1. Does your child have any special health needs or a medical diagnosis the school nurse should know about?
If yes, please explain (all): _____
_____ | Yes | No |
| 2. Did your child have a difficult birth? Were they ever in the NICU?
If yes, please explain: _____
_____ | Yes | No |
| 3. Has your child had any problems with his/her ears and hearing or had tubes in his/her ears in the past?
Current Tubes? | Yes | No |
| 4. Has your child had any trouble with his/her eyes and vision? | Yes | No |
| 5. Does your child wear glasses?
Date of last eye doctor exam: Month _____ Year _____ | Yes | No |
| 6. Is your child allergic to any medications ?
If yes, please list: _____
What reaction happens? _____

How do you treat it? (Medication, etc.) _____
_____ | Yes | No |
| 7. Is your child allergic to any foods ?
If yes, please list: _____
What reaction happens? _____

How do you treat it? _____
_____ | Yes | No |
| 8. Is your child allergic to anything environmental ? _____
What reaction happens? _____

How do you treat it? _____ | Yes | No |
| 9. Has your child been DIAGNOSED with Asthma ?
Does your child use medication for Asthma?
If yes, please list NAME of medication(s), and write DAILY OR AS NEEDED: _____
_____ | Yes | No |
| Does your child have a trigger that causes an Asthma attack?
If yes, please list: _____ | Yes | No |
| Has your child had surgery?
Type of surgery? _____ Date: _____
Type of surgery? _____ Date: _____ | Yes | No |

OVER

Brockway Area School District
Health Department

revised 3/18

- | | | |
|---|-----|----|
| 10. Has your child had any serious accident or illness that they were hospitalized For?
Date: _____ Explain: _____ | Yes | No |
| 11. Has your doctor told you your child has a heart murmur or other cardiac condition? Please explain: _____ | Yes | No |
| 12. Has your child ever fainted or had a seizure?
Please Explain: _____ | Yes | No |
| 13. Does your child have any unusual dietary restrictions or requirements?
Please Explain: _____ | Yes | No |
| 14. Does your child get frequent headaches?
Please Explain: _____ | Yes | No |

Please list any **medications** the student takes on a regular basis (including dose & time of day):

Has your child had any **childhood illnesses**? (Measles, mumps, rubella, roseola, chicken pox, scarlet fever, pertussis, etc.)
Please give month/year: _____

***For the health, safety, and welfare of my child, I give permission for appropriate information to be shared confidentially with my child's teachers and staff, only on an as-needed basis.**

Parent/Guardian Signature

Date

-Family Doctor: _____ Phone: _____

-Family Dentist: _____ Phone: _____

I ALLOW THE SCHOOL NURSE TO CONTACT MY CHILDS' DOCTORS

Parent/Guardian Signature: _____

I permit the school nurse to administer the following medications as prescribed by the school physician to my child :

****BETWEEN THE HOURS OF 10:00AM AND 2:00 PM ONLY:****

_____ Tylenol (Acetaminophen) _____ Antacid (Tums) _____ Benadryl

_____ Motrin/Advil (Ibuprofen) _____ Epi Pen (*emergency- allergic reaction*)

Parent/Guardian Signature

Date

If you have any questions or concerns, please don't hesitate to contact us. Thank you!
-Lesley Martini, RN, CSN 265-8417 -Vicky Heilbrun, LPN 265-8414