Petersburg City Public Schools

School_____

School Year_____

Grade _____

Teacher_____

Student Health History Form

This form must be completed, signed, and returned to the School Nurse within 10 days

Student's Name_____**Date of Birth**_____**Gender**_____

Address: _____

Mother's Name_____**Current Phone #**_____

Email Address_____Cell Phone_____

Work Phone #_____Alternative Phone #_____

Father's Name_____**Current Phone #**_____

Email Address_____Cell Phone_____

Work Phone #_____Alternative Phone #_____

This child is in the custody of: ☐ Mother ☐ Father ☐ Both ☐ Other (Please List)_____
Sibling(s) at Petersburg City Public Schools_____
_____

Emergency Contacts

(Must be able to pick child up from School)

1. _____
   Relationship Phone#
2. _____
   Relationship Phone#
3. _____
   Relationship Phone#

Physician' Name_____**Physician's Phone Number**_____

HEALTH PROBLEMS

Please check appropriate box and describe below

☐ **Allergies (describe below)**	☐ **Cerebral Palsy**	☐ **Headaches**	☐ **Sickle-Cell Anemia**
☐ **Food; Benadryl/ Epi-pen**	☐ **Colostomy**	☐ **Heart Condition**	☐ **Spina Bifida**
☐ **Bee Stings: Benadryl/ Epi-pen**	☐ **Cystic Fibrosis**	☐ **Blood Pressure Disorder**	☐ **Stomach Spasms/Ulcers**
☐ **Asthma: Inhaler / Nebulizer**	☐ **Diabetes**	☐ **Thyroid Condition**	☐ **Tracheostomy**
☐ **Arthritis**	☐ **Ear Problem/Hearing**	☐ **Hyperventilates**	☐ **Vision: Glasses/Contacts**
☐ **Bleeding Disorder/Hemophilia**	☐ **Eating Disorders**	☐ **Menstrual Disorders**	☐ **Other**
☐ **Cancer**	☐ **Emotional Disorders**	☐ **Scoliosis**	
☐ **Catheterization**	☐ **Feeding Tube/G-Tube**	☐ **Seizures/Convulsions**	

Please explain any health problems marked above._____
_____

Student Health History Form (continued)

This form must be completed, signed, and returned to the School Nurse within 10 days

ALLERGIES

List known allergies to food, environment, medication or other. Describe reaction and treatment.

_____
_____
_____

MEDICATIONS

All medication that may need to be administered during the school day must be provided to the school nurse by the parent. Written parental permission and doctor's order as needed is required before medication will be administered at school.

Is your child taking any medications? ☐ No ☐ Yes

If yes, please describe below.

Please identify all prescription and non-prescription medication, and the condition requiring them:

_____
_____
_____

IMPORTANT!!!

1. ***All prescribed and over-the-counter medications must be provided to the nurse by parent.***
2. ***Written permission is required before medication may be administered.***
3. ***Parents/Guardians must provide all medication and treatment supplies.***
4. ***Students must have all required vaccinations.***
    a. ***The up-to-date immunization record must be given to the school nurse.***
5. ***The school nurse must be informed of any medical issues your child is experiencing.***
6. ***Keep your child at home if he/she has:***
    a. ***An oral temperature 100 degrees F or greater***
    b. ***Vomiting***
    c. ***Diarrhea***
    d. ***Rash with fever***
    e. ***Appear severely ill***
7. ***Call the school if your child is sick.***

Insurance Information

Does your child have health insurance? ☐ Yes ☐ No

If yes, please check appropriate box that identifies your type of insurance:

☐ Private/Employer sponsored	☐ VA Premier	☐ Famis
☐ FAMIS PLUS	☐ Sentara	☐ CareNet
☐ Medicaid	☐ Anthem HealthKeepers PLUS	☐ Other_____

If your child does not have health insurance, would you like to learn more about free or low cost health insurance? ☐ Yes ☐ No

PLEASE CHECK BOXES AND SIGN BELOW:

☐ I certify that the information provided on this form is correct to the best of my knowledge.
☐ I give permission for the school to share the information on this form with my child's teacher.
☐ I give permission for the school nurse to contact my child's physician when necessary.

_____Date_____

Parent/Guardian Signature