

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.

Student _____ DOB _____ Grade _____ Teacher _____

Date _____ Parent/Guardian's Signature _____

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"/> Body Piercing/Tattoo | <input type="checkbox"/> Emotional | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone/Spine | <input type="checkbox"/> Hearing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Infections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Vision |
| <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 ended in June?

NO YES Type of illness, with date(s) _____

4. Has your child had surgery since school ended in June?

NO YES Type of surgery, with date(s) _____

5. Has your child received any immunizations since school ended in June?

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, medication forms are on the school website.

8. Has your child ever been examined by an eye doctor?

NO YES Date of last exam _____ Glasses Prescribed NO YES

If your child wears glasses or contact lenses, when was the prescription last changed? _____

9. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?

NO YES List _____

10. What is the name of your child's dentist? _____

What is the date of his/her last dental exam? _____

11. What is the name of your child's primary healthcare provider? _____

What is the date of his/her last physical exam? _____

12. Any additional information that you would like the nurse to know _____

Thank you!

