

HEALTH INFORMATION – 2018-2019 (NEW students)

*This information will be reviewed and maintained in confidential manner
by the School Nurse assigned to your student's school.*

STUDENT NAME: _____ **BIRTH DATE:** _____
First Middle Last

SCHOOL: _____ **GRADE / TRACK:** _____

EARLY CHILDHOOD HEALTH HISTORY

Were there any significant problems during the pregnancy, labor or delivery? No Yes

If yes, is this concern a current issue? No Yes

If yes, please explain? _____

PLEASE CHECK ALL HEALTH CONDITIONS THAT APPLY TO YOUR STUDENT. IF A HEALTH CONDITION PERTAINING TO YOUR STUDENT HAS A COMMENT FIELD, PLEASE PROVIDE ADDITIONAL INFORMATION IN THE FIELD.

Dietary Needs – Comment required

Student has Special Dietary Needs **Comment:** _____

Allergies – Life Threatening – Comment required

- Life threatening allergy – Dairy **Comment:** _____
- Life threatening allergy – Food **List Food(s):** _____
- Life threatening allergy – Insect Sting **Comment:** _____
- Life threatening allergy – Latex **Comment:** _____
- Life threatening allergy – Peanut **Comment:** _____
- Life threatening allergy – Tree Nuts **Comment:** _____
- Life threatening allergy – Other **List:** _____
- Life threatening allergy – Unknown **Comment:** _____

Allergies – Comment required where indicated

- Animal
- Environmental/Seasonal
- Food **List Food(s):** _____
- Insect Sting
- Latex
- Medication **List Medication(s):** _____
- Non-Specific

Other Conditions – Comment required where indicated

- ADD/ADHD – Name of medication: _____
- Alopecia
- Arthritis Juvenile
- Asthma **Comment:** _____
- Autism Spectrum **Comment:** _____
- Auto-Immune Condition **Comment:** _____
- Blood Disorder **Comment:** _____



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<input type="checkbox"/> Cancer	Comment: _____
<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Chromosomal Anomalies	Comment: _____
<input type="checkbox"/> Crohn's Disease	
<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> Diabetes	Comment: _____
<input type="checkbox"/> Down Syndrome	
<input type="checkbox"/> Emotional Condition	Comment: _____
<input type="checkbox"/> Encopresis	Comment: _____
<input type="checkbox"/> Enuresis	Comment: _____
<input type="checkbox"/> Fetal Alcohol Syndrome	
<input type="checkbox"/> Frequent Headaches	Comment: _____
<input type="checkbox"/> Gastrointestinal Disorder	Comment: _____
<input type="checkbox"/> Head Injury/Concussion	Comment: _____
<input type="checkbox"/> Hearing Impaired	Comment: _____
<input type="checkbox"/> Heart Condition – No Restriction	Comment: _____
<input type="checkbox"/> Heart Condition – Restrictions	Comment: _____
<input type="checkbox"/> Hepatitis B Carrier	
<input type="checkbox"/> Hepatitis C Carrier	
<input type="checkbox"/> History of Injuries	Comment: _____
<input type="checkbox"/> Hypoglycemia	Comment: _____
<input type="checkbox"/> Immune Compromised	Comment: _____
<input type="checkbox"/> Kidney Problem	Comment: _____
<input type="checkbox"/> Lactose Intolerant	
<input type="checkbox"/> Long QT Syndrome	
<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Myalgia Myositis Fibromyalgia	Comment: _____
<input type="checkbox"/> Neurologic Disorder	Comment: _____
<input type="checkbox"/> Nosebleeds	
<input type="checkbox"/> Orthopedic – Physical Limitation	Comment: _____
<input type="checkbox"/> Orthopedic – No Restrictions	Comment: _____
<input type="checkbox"/> Other	List: _____
<input type="checkbox"/> Paraplegia	
<input type="checkbox"/> Quadriplegia	
<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Seizure Disorder	Comment: _____
<input type="checkbox"/> Shunt/Hydrocephalus	Comment: _____
<input type="checkbox"/> Skin Condition	Comment: _____
<input type="checkbox"/> Syncopal Episodes	Comment: _____
<input type="checkbox"/> Syndrome	Comment: _____
<input type="checkbox"/> Thyroid Condition	
<input type="checkbox"/> Tourette Syndrome	Comment: _____
<input type="checkbox"/> Tracheostomy	Comment: _____

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- Traumatic Brain Injury **Comment:** _____
- Urinary Problem **Comment:** _____
- Wears Glasses/Contacts
- Vision Impaired **Comment:** _____
- Von Willebrand's Disease
- Wolff Parkinson White Syndrome

ADDITIONAL INFORMATION

- List any illness, hospitalization, surgery, accidents your student had in the past year. **None**

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

- List any emotional, social or other conditions that might affect your student's school performance. **None**

- Is your student *currently* taking any medication, including over-the-counter medication? **No** **Yes**

- If your student will need to be given medication at school, a Provider Medication Authorization Form for each medication will be needed. If your student is a middle school student and will self-carry prescription medication, a Permission to Carry Form must be completed for each medication. High school students may self-carry and self-administer one-day supply of medication, carried in a pharmacy labeled container.
- Is your student currently receiving alternative therapies (acupuncture, homeopathic, herbal, biofeedback, etc)? **No** **Yes**

If yes, please explain: _____

- **Is there anything else you would like us to know about your student?** **No** **Yes**

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ **Date** _____