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