STUDENT HEALTH HISTORY UPDATE 2023-2024

This information will be shared with staff, administration and emergency medical staff on a need to know basis unless you notify us otherwise.

Date_____ Parent/Guardian Signature_____

Student_____DOB_____Grade_____

PLEASE CHECK IF YOUR CHILD HAS OR HAS HAD ANY OF THE FOLLOWING. GIVE DATES AND ADDITONAL INFORMATION UNDER COMMENTS.

1.

( ) ADD/ADHD	( ) Bone/Spine	( ) Ear/Hearing	( ) Physical Disability
( ) Allergies	( ) Bowel/Bladder	( ) Emotional	( ) Seizures
( ) Asthma	( ) Chicken Pox	( ) Eye/Vision	( ) Speech
( ) Behavior issues	( ) Diabetes	( ) Heart	( ) Surgery
( ) Blood Disorder	( ) Kidney	( ) Infections	( ) Other _____

COMMENTS:_____
_____
_____

2. Does your child have allergies to medicine, food, latex or insect bites?
   Yes ( ) No ( ) To what_____What happens_____
   Treatments_____

3. Has your child had any illnesses or general health concerns in the last 12 months?
   Yes ( ) No ( ) Type of illness/health concern and date(s)_____
   Did your child see a doctor for this or receive medication or treatment?
   Yes ( ) No ( )
   Comments_____

4. Has your child had surgery in the last 12 months?
   Yes ( ) No ( )
   Type of surgery and date(s)_____
   Comments_____

5. Does your child take **any** medications (prescriptions or over the counter), or treatments on a regular basis?
   Name of medication/treatment, doses, and time taken_____
   _____
   Will these medications be taken during school hours?
   Yes ( ) No ( ) *If yes, please contact the school nurse.
   When was your child last seen by the doctor concerning these medications?_____

6. Does your child receive any treatments?_____For?_____

7. When was your child's last physical exam (including immunization review)?_____
   Name of child's primary healthcare provider_____

8. Has your child had any emotional upsets in the past 12 months (death, separation, divorce or recent move)
   Yes ( ) No ( ) Comments_____
   _____

9. Does your child wear corrective lenses or glasses? Yes ( ) No ( ) Date of last exam_____
   Name of doctor?_____

10. Does your child have any dental problems? Yes ( ) No ( ) Date of last exam_____
    Name of doctor?_____