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.

*Date*_____*Parent/Guardian's*

*Signature*_____

*Student*_____ *DOB:*_____ *Grade*_____ *Teacher*

_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1. ☐ ADD/ADHD ☐ Allergies ☐ Asthma ☐ Blood Disorder ☐ Body Piercing/Tattoo ☐ Bone/Spine ☐ Bowel/Bladder ☐ Diabetes ☐ Emotional ☐ Hearing ☐ Heart ☐ Infections ☐ Kidney ☐ Physical Disability ☐ Seizures ☐ Speech ☐ Surgery ☐ Vision

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 last ended?

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

_____

4. Has your child had surgery since school last ended?

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

_____

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

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, please contact the school nurse to make arrangements.***

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

   NO☐ YES☐ Date of last exam_____

   NO☐ YES☐ Glasses Prescribed

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

   _____

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

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

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

    _____

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

11. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year?

☐NO YES☐***If yes, please contact your School Nurse or School Counselor.***

12. Have you, your child or anyone in your household tested positive for COVID-19?

☐*NO YES*☐***If yes, please contact the school nurse.***

Revised 7/17/2020