Health History Form

The following is a brief health history form. The Information is essential for the school to be properly prepared to take care of any special health needs your child may have during the school day. Please be assured that this information will be guarded with confidentiality and only shared with school personnel as necessary. Please keep this information up to date. Staff conference may be required or can be requested by parent/guardian.

Student name: _____ Date of Birth:_____ Grade: _____ School:_____

PLEASE CHECK BELOW IF YOUR CHILD HAS ANY OF THE FOLLOWING:

⬜ **No medical information to report**

⬜ADD/ADHD Medications? ⬜Home ⬜School	⬜Depression
⬜ Behavioral/Emotional	⬜Eating Disorder
⬜Blood Disorder	⬜Headaches/Migraines Triggers:
⬜Bowel/Bladder	⬜Hearing Problems Hearing aid? ⬜Yes ⬜ No
⬜Cancer Type:	⬜Heart Condition
⬜Cerebral Palsy	⬜Visually Impaired Glasses? ⬜ Yes ⬜ No
⬜Cystic Fibrosis	⬜Special Diet
⬜Other	
Skilled Procedures: ⬜Tube feeding ⬜Catheterization ⬜Tracheotomy/Suctioning ⬜Other	
Physical Restrictions (Physician's note required)	
Medication required at school (medication form required):	

Please explain any of the above:

_____

_____

_____

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The following conditions require an Emergency Action Plan with signatures from parents/guardian and health care provider.

⬜ **Allergies:** ⬜ Insect ⬜ Latex ⬜ Food **Food List:** _____ **Reaction:** _____ ⬜ Medication at school ⬜ No medication required **Location of medicine:** ⬜ Student ⬜ Office ⬜ EpiPen ⬜ Auvi-Q ⬜ Oral Medication	⬜ **Asthma** **Triggers:** ⬜ Exercise ⬜ Environmental Other: _____ ⬜ Medication at school ⬜ No medication required Location of medicine: ⬜ Student ⬜ Office ⬜ Self-administered
⬜ **Diabetes** ⬜ Pen ⬜ Pump ⬜ Requires daily intervention from school staff ⬜ Self-Managed	⬜ **Seizure Disorder** ⬜ Medication at school ⬜ No medication required **Location of medicine:** ⬜ Student ⬜ Office History of seizure, but not presently medicated **Date of last seizure:** _____

Parent/Guardian Signature: _____ **Date:** _____ *2*