Health History Form

This health and development form must be completed by the parent or guardian prior to each school year. It will be reviewed by the school nurse.

Student's Name ________________________________ Today's Date_________________

Date of birth____________________________________ Grade______________________

Does your child take any medication on a routine basis? ___Yes ___No

If yes do they take this medication during school hours? ___Yes ___No

1. Name and purpose of medication ____
2. Name and purpose of medication ____
3. Name and purpose of medication ____

Please contact the school office regarding the "Medications at School" policies if your child must take prescriptions or over the counter medications during the school day.

- ❏ Check box and explain if your child has a history of, or has the following conditions of concerns.

History of:	Yes	No	If yes, Moderate or Severe
Asthma	____	____	________________________
Rescue Inhaler at home	____	____	________________________
Rescue Inhaler with student	____	____	________________________
History of Seizures	____	____	
Is medication used?	____	____	

If yes, what and when. _____________________________________

In case of an event, parent/guardian desire the following treatment:

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	Yes	No	If yes,	Moderate or Severe
Diabetes	____	____		________________________
Is medication used?	____	____		
If yes, what and when.	____	____		________________________________

Allergies ____ Mild ____ Moderate ____ Severe

Bees/Insects ____

Foods____

Seasonal Heyfever____

Medications____

Other (please be specific) ____

Please describe all moderate to severe allergies.

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Does your child require an Epi-pen for severe allergies? ____ Yes ____ No

If yes an Epi-pen prescription will be required to on file along with medication.

Does your child have a history of a heart murmur/disease? ____ Yes ____ No

Is medication used? ____ Yes ____ No

If yes, what and when? ___________________________

If yes, please describe condition completely. ____

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Does your child have a history of any other health concerns? ____ Yes ____ No

If yes, please describe condition completely. ____

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