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.***

Date:_____ Parent/Guardian's Signature:_____

Revised 7/17/2020