Student Health History Update Sheet Student Name: _____

PEDIATRICIAN/PRIMARY CARE PROVIDER: _____ **Date of Last visit:**_____

Eye Doctor: _____ Last Vision Exam: _____ Dentist: _____ Last Dental Exam: _____

Significant Surgical History (please list procedure/year): _____

Does your child have any of the following? **Wears glasses:** yes/no **Heart problems:** yes/no

Wears contacts: yes/no **Migraines:** yes/no **Wears hearing aid:** yes/no **Bleeding Disorder:** yes/no

Disability: yes/no **Activity restriction:** yes/no

If answer is yes to any of the above, please provide more details here: _____

_____

Does your child have asthma? yes/no If yes, mild_____ moderate_____ severe_____

Asthma medications taken_____ Exercise induced? yes/no

When was the last time your child used an inhaler? _____

Will your child require an inhaler to be kept at school? yes/no *If yes, see nurse for necessary forms.

Does your child have an allergy? yes/no If yes, mild_____moderate_____life-threatening_____

Allergen_____ Epipen prescribed? yes/no * If yes, see nurse for necessary forms.

Will your child require a peanut free lunch table? yes/no

Does your child have any of the following medical conditions:

Diabetes: yes/no **Epilepsy:** yes/no Other concerns: _____

*If answer is yes to any of the above, please see nurse for necessary forms.

Is your child currently taking any medications? yes/no If yes, name/dose of medication: _____

Is medication required during school hours? yes/no If yes, see nurse for necessary forms.

Name of medication needed to be administered at school: _____ Reason:_____

I give the school nurse permission to contact my child's doctor to discuss the health of my child or in the event that it becomes medically necessary throughout the 2024-2025 school year. Yes____ No____

All of the information provided above is true and complete to the best of my knowledge. I understand that in order to provide the safest possible environment for my child, the school needs to be informed of any health and medical conditions that may affect my child's school day. Yes____ No____

I understand that medications of any kind are not allowed on school grounds or on the bus without the proper medical authorization on file. If my child needs medication, I will provide it to the school and will not send it in with my child. I understand that school staff, including the nurse, MAY NOT administer or assist with any medications without the proper medical authorization on file. Yes_____ No_____

I understand that for the safety of my child, the school nurse may need to share information about my child's condition with appropriate school staff. If I do not wish that information is shared, I must request this in writing and file it with the school nurse. Yes_____ No_____

Signature:_____ **Relationship to student:** _____**Date:** _____