2016-2017 Health History Form

Student Name:_____
Date of Birth:_____/_____/_____Grade: _____
School: _____ Age: _____ Sex: ☐ M ☐ F
Parent/Guardian Name: _____ Home Phone:_____
Cell Phone: _____ Work Phone:_____

PLEASE ATTACH a copy of current immunizations from the Physician or Clinic. Students will NOT BE PERMITTED TO ENROLL without proof of state required immunizations.

Medication:
Does your student take medications? ☐ No ☐ Yes Diagnosis/Reason_____

Medication	Dose	Time(s)

Health Information:
Physician's Name _____ Phone (_____)_____-_____ Date of Last Visit _____
Dentist's Name _____ Phone (_____)_____-_____ Date of Last Visit _____
Hospital Preference _____

Has your child had or does your child have any of the following illnesses or diseases?

		Age	Date			Age	Date
Chicken Pox	☐ No ☐ Yes	_____	_____	Mononucleosis	☐ No ☐ Yes	_____	_____
Fifth's Disease	☐ No ☐ Yes	_____	_____	Scarlet Fever	☐ No ☐ Yes	_____	_____
Hepatitis	☐ No ☐ Yes	_____	_____	Strep Infection	☐ No ☐ Yes	_____	_____
Meningitis	☐ No ☐ Yes	_____	_____	Other Contagious Disease	☐ No ☐ Yes	_____	_____

- •Allergies(foods, medications, environment, animals, etc.)..... ☐ No ☐ Yes
- •Asthma ..... ☐ No ☐ Yes
- •Attention Deficit/Hyperactive Disorder ..... ☐ No ☐ Yes
- •Behavior Problems ..... ☐ No ☐ Yes
- •Bladder Problems ..... ☐ No ☐ Yes
- •Bowel Problems..... ☐ No ☐ Yes
- •Broken Bones..... ☐ No ☐ Yes
- •Dental Problems ..... ☐ No ☐ Yes
- •Diabetes ..... ☐ No ☐ Yes
- •Frequent Ear Infections ..... ☐ No ☐ Yes
- •Head Injury/Concussion..... ☐ No ☐ Yes
- •Hearing Problems ..... ☐ No ☐ Yes
- •Heart Problems/Murmur..... ☐ No ☐ Yes
- •Hospitalizations (other than newborn)..... ☐ No ☐ Yes
- •Injuries/Accidents ..... ☐ No ☐ Yes
- •Mental/Emotional Problems..... ☐ No ☐ Yes
- •Physical Limitations..... ☐ No ☐ Yes
- •Pneumonia..... ☐ No ☐ Yes
- •Rash/Birthmark/Scar ..... ☐ No ☐ Yes
- •Seizure Disorder..... ☐ No ☐ Yes
- •Speech Problems..... ☐ No ☐ Yes
- •Surgery..... ☐ No ☐ Yes
- •Sutures/Stitches..... ☐ No ☐ Yes
- •Tube Feeding..... ☐ No ☐ Yes
- •Tubes in Ears..... ☐ No ☐ Yes
- •Wears Glasses/Contacts..... ☐ No ☐ Yes
- •Wheel Chair..... ☐ No ☐Yes

Please explain yes answers here:_____
_____
_____
_____

Student Concerns:
Do you have any concerns about your student's:

Vision ☐ No ☐ Yes Hearing ☐ No ☐ Yes Attention Span ☐ No ☐ Yes Emotional Development ☐ No ☐ Yes
Speech ☐ No ☐ Yes Behavior ☐ No ☐ Yes Ability to Learn ☐ No ☐ Yes Physical Development ☐ No ☐ Yes

Please explain yes answers here:
_____
_____
_____
_____
_____

In Case of Emergency and Parent/Guardian cannot be reached:
Contact #1 Name: _____ Phone Number: _____Relationship:_____
Contact #2 Name: _____ Phone Number: _____Relationship:_____

Medication Administration Procedures

Our schools policy for bringing in daily prescription medication or OTC medication has changed to meet safety guidelines issued by The Manual of School Health Programs. Parents will be required to count medications brought to school with the school Health Aide or personnel. They will then sign off on the official count. The count, date and time will be initialed by parent and personnel checking in medication. Each time a student's personal prescription medication is dispensed, the pill count will be recorded along with the number of remaining pills and initials of personnel dispensing medication. At the end of each day a final count of remaining medication will be taken. After completing count, initials of personnel will be recorded to verify the correct amount of medication is remaining. Medication cabinet is to remain locked at all times. The Health Aide will keep the key in a designated area only known to trained personnel. The Health Office will be locked when nobody is in the room. Students are not allowed to be in the Health Office without adult supervision at all times. New students must provide a copy of his/her immunization record for school entry. If immunizations are updated through the year, please send documentation to the school Health Office. If you have any questions or concerns regarding your child's medical care, please call the Health Aide at (660)564-3320.

Verification:
In case of illness or injury of my student, I understand the school will attempt to contact parents or guardians first. Then they will contact other persons I have listed- who are authorized to receive information, make certain medical decisions and have my student released to their custody. If none is available, the school is authorized to make whatever arrangements are deemed necessary to maintain my student's health including, but not limited to, emergency medical treatment.

I am the legal Parent/Guardian of this student. ☐ No ☐ Yes _____ Initials

If you are not the legal Parent/Guardian of this student, state your relationship to this student. _____

I verify that the information provided on this form is accurate and current.

X_____ _____ _____
SIGNATURE of Parent/Guardian/Other PRINTED Name of Parent/Guardian/Other Date