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 [ ] Body Piercing/Tattoo [ ] Emotional [ ] Physical Disability
   [ ] Allergies [ ] Bone/Spine [ ] Hearing [ ] Seizures
   [ ] Asthma [ ] Bowel/Bladder [ ] Heart [ ] Speech
   [ ] Behavior [ ] Chicken Pox [ ] Infections [ ] Surgery
   [ ] Bleeding [ ] Diabetes [ ] Kidney [ ] 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 ended in June?
   NO [ ] YES [ ] Type of illness, with date(s)_______________________________________
4. Has your child had surgery since school ended in June?
   NO [ ] YES [ ] Type of surgery, with date(s)______________________________________
5. Has your child received any immunizations since school ended in June?
   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. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?
   NO [ ] YES [ ] List____
10. What is the name of your child's dentist? _____________________________________
    What is the date of his/her last dental exam? ___________________________________
11. What is the name of your child's primary healthcare provider? __________________________
    What is the date of his/her last physical exam? _________________________________

Thank you.