HEALTH HISTORY FORM

Student Name ____ Birth Date_______________

Please complete the medical information below for your child, so our nurses can provide the best care possible while your child is in school.

Does your child have any chronic or recurrent illnesses or conditions that we should be aware of?

____

Any Serious accidents or Injuries? ____

Any recent Hospitalizations or Operations? ____

Emotional concerns or Diagnosis? ____

Does your child have any of the following illnesses/ concerns?

Seizures? ____

Diabetes? ____

Asthma? ____

Allergies? ____

Seasonal? ____

Food? ____

Are there any other health concerns you feel the Nurse should be aware of?

____
____
____

Please list below any medications that your child takes at home.

____ ____

Would any of these medications need to be given during school hours? YES _____ NO _____

Would you like a conference with the school nurse? YES _____ NO _____

Can medical information you provided be shared with school staff? YES _____ NO _____

We have and can administer the following medication to your child with your permission if it were to be needed. Please indicate your permission below.

Tylenol	YES _____	**Motrin**	YES _____	**Tums**	YES _____
	NO _____		NO _____		NO _____

PARENT SIGNATURE ____ DATE ____________________