Student: _____

STUDENT HEALTH HISTORY: 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.

Please check if the student has had difficulty with any of the follow (select all that apply). Please provide additional information in the *Please Specify* section.

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Behavior
- ☐ Bleeding/Blood Disorder
- ☐ Body Piericing /Tatoo
- ☐ Bone/Spine
- ☐ Bowel/Bladder
- ☐ Concussion
- ☐ Diabetes
- ☐ Hearing
- ☐ Heart
- ☐ Infections
- ☐ Kidney
- ☐ Physical Disability
- ☐ Seizures
- ☐ Speech
- ☐ Surgery
- ☐ Vision
- ☐ Other

Please Specify: _____

Does your student have allergies to medicine? ☐ Yes ☐ No
If yes, please describe what hapopens and treatment for reaction: _____

Will your student require an individualized allergen-free menu? ☐ Yes ☐ No

Has your student seen a healthcare provider since last june? ☐ Yes ☐ No
If yes, for what reason: _____

Is your student being evaluated or treated for any health conditions? ☐ Yes ☐ No
If yes, for what reason: _____

Is your student on any medication or treatment? ☐ Yes ☐ No
If yes, please name the medication or treatment: _____

Does your student need any medication during school hours? ☐ Yes ☐ No
If yes, please list the medications: _____

Has your student been prescribed glasses or contact lenses? ☐ Yes ☐ No
If yes, please provide date of the last exam, and date prescription last changed if your student wears glasses: _____

As the parent/guardian, I give my permission for _____ to have the following medications administered by the school nurse during the current school year. I understand that they will be checked by the school nurse and the medications will be administered if indicated following the nurse's assessment.

Please check only those medications you wish to be given to your student when needed.

- ☐ Advil/Ibuprofen/Motrin
- ☐ Eye Wash Solution/Saline Rinse
- ☐ Anbesol/Orajel
- ☐ Hygiene Supplies
- ☐ Anti-Fungel Cream
- ☐ Lip Ointment (Blistex/Chapstick)
- ☐ Benadryl Liquid
- ☐ Skin Ointment (Bacitracin/Hydrocortisone/Neosporin)
- ☐ Benadryl Lotion (Anti-Itch)
- ☐ Sting Kill (Insect Sting Relief)
- ☐ Burn Ointment/Spray
- ☐ Throat Spray (Chloraseptic Spray)
- ☐ Caladryl/Calamine Lotion
- ☐ Tums
- ☐ Cough Drops
- ☐ Tylenol/Acetaminophen

I certify that I am the legal parent or guardian of this student and that the information represented herein is complete and accurate.

_____ _____
Parent/Guardian Signature **Date**