

Child's name _____ Birth date _____ School _____ Grade _____
 Physician _____ Preferred Hospital _____ Health Insurance Co. _____

Health history: **Please complete both sides of this form.** This information is considered CONFIDENTIAL and is for use by the nurse, health room staff, teacher(s), building administrators, and others as needed to ensure your child's safety and protection at school.

Indicate below the medical conditions that may affect the student's school program or school performance.

STAFF: Notify school nurse immediately if parent/guardian lists condition in grey area.

Computer Code	Health History/Condition	Current		Medications <i>"Medication at School" form must be completed for school administration</i>	Check (√) if needed at school	Comments
		Yes	No			
EG & OB (staff enter both codes and list allergy type)	Anaphylactic allergy (life threatening) Insect _____ Bee _____ Food _____ Environmental _____			(service animals may be in buildings)		Specify source of allergy ie- peanuts, smoke, dogs etc
EK	Diabetes-Type 1					
NP	Seizure Disorder					Indicate type of seizure
RD	Asthma Severe					Specify factors contributing to flair-ups:
RB	Asthma- Mild ____					Specify factors contributing to flair-ups:
RC	Moderate ____					
RE	Reactive Airway Dis. _____					
EE	Allergy- mild/localized			(service animals may be in buildings)		Specify source of allergy ie- peanuts, smoke, dogs etc.
ED	Insect _____ Bee _____ Food _____					
EC	Environmental _____					
AN	Medicine Allergy _____					
EJ	Cystic Fibrosis					
GG	Food Intolerance _____					
CA	Cardiac Disorder _____					Specify condition if "Cardio-vascular - other":
CD	Heart Murmur _____					
CE	Hypertension _____					
BB	Hemophilia _____					

COMPLETE BACK SIDE AND SIGN/DATE- RETURN TO STUDENT'S SCHOOL OFFICE

Computer Code	Health History/Condition	Current		Medications <i>"Medication at School" form must be completed for school administration</i>	Check (√) if needed at school	Comments
		Yes	No			
EA EU EO	Adrenal Disorder ____ Thyroid Disorder ____ Endocrine and/or metabolic disorder _____					Specify condition if "Endo/Metabol. – other":
NU	Traumatic Brain Injury					Indicate date of last injury:
PA	Anxiety Disorder					
YB YD	Hearing Impaired - R ____ L ____ Visually impaired- R ____ L ____					Exam date/results: Exam date/results:
MD MC ECC	Muscular dystrophy ____ Juvenile Rheum Arthritis ____ Eczema					Specify condition if "Musculo/skeltl – other":
NE	Cerebral Palsy					
UA UE GF	Chronic Renal Failure ____ Incontinence—bladder Encopresis - bowel					Specify condition if "Genito/Urinary- other":
TA TI	Neoplasm (cancer) blood and or circulatory ____ Neoplasm (cancer) other _____					Specify condition if "Neoplasm (cancer) – other":
NS	Spina Bifida					
NB	ADD/ADHD					
NC	Autism					

Other Conditions or Comments: _____

No child may take medication (prescription or over-the-counter) at school without a completed medication administration form (s) including signature by Health Care Provider and/or parent/guardian. Forms may be picked up in the office or at your provider's. **Please provide information to school in writing if you have special instructions regarding religious beliefs.**

Do you need health insurance for your children? Please initial if you are interested in being contacted by our Education Advocate/ school staff: _____
(Do not initial if you already have health insurance coverage.)

AUTHORIZATION FOR EMERGENCY PROCEDURE: If the parent(s)/guardian named above cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to contact emergency medical aide and send the student to the hospital or doctor most easily accessible. I understand that I will assume full responsibility of the payment of any services rendered.

Parent/guardian Signature _____ Date _____