Brockway Area School District revised 3/18
Health Department

Student Health History Form

Dear Parent or Guardian,
To ensure proper medical treatment at school we rely on you to keep the school informed of new developments regarding your child's health. Please complete the **front and back** of this form and provide **signatures** where requested so we have current health information in your child's file for their attendance in school each year.

Student's Name: _____ Date of Birth: _____

Please circle:

1. Does your child have any special health needs or a medical diagnosis the school nurse should know about? Yes No
   If yes, please explain (all): _____
   _____

2. Did your child have a difficult birth? Were they ever in the NICU? Yes No
   If yes, please explain:_____
   _____

3. Has your child had any problems with his/her ears and hearing or had tubes in his/her ears in the past? Yes No
   Current Tubes? Yes No

4. Has your child had any trouble with his/her eyes and vision? Yes No
5. Does your child wear glasses? Yes No
   Date of last eye doctor exam: Month _____ Year_____

6. Is your child **allergic** to any **medications**? Yes No
   If yes, please list: _____
   What reaction happens? _____
   _____
   How do you treat it? (Medication, etc.) _____
   _____

7. Is your child **allergic** to any **foods**? Yes No
   If yes, please list: _____
   What reaction happens? _____
   _____
   How do you treat it? _____
   _____

8. Is your child **allergic** to anything **environmental**? _____ Yes No
   What reaction happens? _____
   _____
   How do you treat it? _____

9. Has your child been DIAGNOSED with **Asthma**? Yes No
   Does your child use medication for Asthma? Yes No
   If yes, please list NAME of medication(s), and write DAILY OR AS NEEDED:
   _____
   Does your child have a trigger that causes an Asthma attack? Yes No
   If yes, please list: _____

   Has your child had surgery? Yes No
   Type of surgery? _____Date: _____
   Type of surgery? _____Date: _____

OVER

10. Has your child had any serious accident or illness that they were hospitalized For? Yes No
    Date: _____ Explain: _____

11. Has your doctor told you your child has a heart murmur or other cardiac condition? Please explain: _____ Yes No

12. Has your child ever fainted or had a seizure? Yes No
    Please Explain: _____

13. Does your child have any unusual dietary restrictions or requirements? Yes No
    Please Explain: _____

14. Does your child get frequent headaches? Yes No
    Please Explain: _____

Please list any **medications** the student takes on a regular basis (including dose & time of day):
_____
_____

Has your child had any **childhood illnesses**? (Measles, mumps, rubella, roseola, chicken pox, scarlet fever, pertussis, etc.)
Please give month/year: _____

*For the health, safety, and welfare of my child, I give permission for appropriate information to be shared confidentially with my child's <u>teachers and staff</u>, only on an as-needed basis.

_____ _____
Parent/Guardian Signature **Date**

-Family Doctor: _____ Phone: _____

-Family Dentist: _____ Phone: _____

I ALLOW THE SCHOOL NURSE TO CONTACT MY CHILDS' DOCTORS

Parent/Guardian Signature:_____

I permit the school nurse to administer the following medications as prescribed by the school physician to my child :

****BETWEEN THE HOURS OF 10:00AM AND 2:00 PM ONLY:****

_____ Tylenol (Acetaminophen) **_____ Antacid (Tums)** **_____Benadryl**

_____ Motrin/Advil (Ibuprofen) **_____ Epi Pen (*emergency- allergic reaction)***

_____ _____
Parent/Guardian Signature **Date**

If you have any questions or concerns, please don't hesitate to contact us. Thank you!
-Lesley Martini, RN, CSN 265-8417 **-Vicky Heilbrun, LPN 265-8414**