Student Health History

STUDENT INFORMATION

Name: ____ Gender: ________ Birthdate: ______________
last first middle initial

Grade: ______________ Teacher: ______________________ School Attending: ______________________

Parent/Guardian: ___________________________ Home Phone: ______________________ Work Phone: ______________________

HEALTH CONDITIONS AND HISTORY

1. Were there any pregnancy or birth related complications?

☐ No ☐ Yes (please explain) ____

2. Has your child ever been hospitalized or had a serious injury or serious illness?

☐ No ☐ Yes (please explain) ____

3. Does your child have any chronic health conditions or problems diagnosed by a doctor? Check all that apply:

☐ ADHD
☐ Anxiety
☐ Asthma
☐ Bowel or Bladder Problem *(specify below)*
☐ Concussion History
☐ Constipation
☐ Diabetes List Type:
☐ Depression
☐ Eating Disorder *(specify below)*
☐ Headaches
☐ Hearing Problem/ Hearing Aids
☐ Heart Disorder *(specify below)*
☐ Seizures
☐ Vision Problem or Glasses/Contacts
☐ Other

Please explain any of the above:

____

____

____

____

Allergies (list) Environmental: ____

Food: ____

Medications: ____

4. Is there anything more about your child's physical or emotional state that you feel we should know? Please explain:

____

____

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PLEASE COMPLETE OTHER SIDE

STUDENT MEDICATION INFORMATION

List **ALL** medications that your child takes (prescribed regularly or as needed AND over the counter medications). Please note that this does NOT take place of a medication consent form for any medications needed at school. See below for more information.

Medication Name:	Reason for Medication:	Dose:	Taken Daily or As Needed?
______________________	______________________	________	______________
______________________	______________________	________	______________
______________________	______________________	________	______________
______________________	______________________	________	______________
______________________	______________________	________	______________

If your child needs to take medication at school, please note the following:

1. The Authorization for Administration of Medication form is **REQUIRED** for all medication(s) taken at school, including non-prescription (over the counter) medications. Students must take all medications at school in the health office unless otherwise arranged individually with the school nurse.
2. The Authorization for Administration of Medication form must be signed by both a licensed presciber and a parent/guardian for medications to be administered at school. A new consent form is needed each school year or when the medication and/or dose is changed.
3. Forms are available in the health office or on the District's website at www.sspps.org/healthservices.

In order to provide for the health and safety of your child, the above information may be shared with school staff working with your student and with Emergency Response Personnel in the event that 911 is called. Please note: Parents are responsible for the costs incurred with treatment and/or transportation by emergency response personnel or paramedics (911).

PREFERRED HOSPITAL IN CASE OF AN EMERGENCY: ____

Parent/Guardian Name: ______________________________
print name

Parent/Guardian Signature: ______________________________ **Date:** ______________________

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequences for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success.