



HEALTH HISTORY FORM

Academic Year 2018-2019

{Both parents must sign the back of this form}

Student's Full Name: _____ Male { } Female { }

Date of Birth: _____ Parent/Guardian: _____

Contact Phone: _____

MEDICAL

Name of Doctor: _____ Phone: _____

Name & Address of Medical Facility: _____

Medical Record Number _____ Date of last physical: _____

DENTAL (if none, please write none)

Name of child's dentist: _____ Phone: _____

Address: _____

Date of last exam: _____

HEARING/VISION

Does your child have hearing loss? Yes ___ No ___

Are hearing aides required? Yes ___ No ___

Does your child have vision loss? Yes ___ No ___

Are glasses or contacts required? Yes ___ No ___

Remarks _____

SPEECH/LANGUAGE

Is English your primary language? Yes ___ No ___ If not, what is? _____

Do others have difficulty understanding your child? Yes ___ No ___

Remarks _____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

- ___ Asthma ___ Bleeding disorder ___ ADD/ADHD ___ Learning disability
___ Diabetes ___ Bone/muscle disease ___ Skin condition ___ Seizure disorder
___ Heart condition ___ Mental health condition
(i.e. depression, anxiety, eating disorder)

Other _____

Does your child experience any of the following?

- ___ Nose bleeds ___ Frequent ear aches ___ Overweight for age ___ Physical disability
___ Poor appetite ___ Frequent stomach aches ___ Frequent headaches ___ Fainting spells
___ Tires easily ___ Emotional concerns ___ Underweight for age

Other _____

Do any of the above condition(s) limit/effect your child at school? Yes ___ No ___

ALLERGIES

___ Plants ___ Animals ___ Food * (see back) ___ Molds ___ Drugs ___ Bees

Other _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes ___ No ___

Describe: _____

MEDICATION

Does your child take any medications? Yes ___ No ___ If yes, name medication _____

Purpose: _____ Will medication be needed at school? Yes ___ No ___

***FOOD ALLERGY ASSESSMENT FORM**

Doctor treating food allergy: _____ Phone: _____ Facility: _____

Do **you think** your child's food allergy may be **life-threatening**? Yes ___ No ___

Did your child's **doctor tell you** the food allergy may be **life-threatening**? Yes ___ No ___

Has your child's **doctor** required an **allergy free environment** at home Yes ___ No ___ and/or in the classroom?
Yes ___ No ___ If your doctor is requiring an allergy free classroom, his/her letter must be attached.

If your child has a life-threatening food allergy, parents must provide snack for their children to keep in their classroom.

HISTORY and CURRENT STATUS

Check the foods that have caused an allergic reaction:

___ Peanuts/Peanut butter/Peanut oil ___ Tree Nuts (walnuts, almonds, pecans, etc.)
___ Fish/shellfish ___ Eggs ___ Milk/dairy ___ Soy products

Please list any others: _____

How many times has your student had a reaction? Never ___ Once ___ More than once ___

Explain: _____

When was the last reaction? _____

Are the food allergy reactions: Staying the same ___ Getting worse ___ Getting better ___

TRIGGERS AND SYMPTOMS

What has to happen for your student to react to the problem food(s)? (Check all that apply)

___ Eating foods ___ Touching foods ___ Smelling foods

___ Other, please explain: _____

Is it possible for other classroom students to have the identified products in their lunch/snack as long as they sit at a different table? Yes ___ No ___ (If No, a letter from your doctor must be attached.)

What are the signs and symptoms of your child's allergic reaction? (Be specific; include things the student might say.)

How quickly do the signs and symptoms appear after exposure to the food(s)?

Seconds ___ Minutes ___ Hours ___ Days ___

TREATMENT

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

Yes ___ No ___ Explain: _____

Does your student understand how to avoid foods that cause allergic reactions? Yes ___ No ___

What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

Have you used the treatment? Yes ___ No ___

Does your child know how to use the treatment? Yes ___ No ___ Describe any side effects or problems your child had in using the suggested treatment: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

*I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered. **BOTH PARENTS MUST SIGN THIS FORM.***

Parent/Guardian Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____