Skinner
ELEMENTARY MONTESSORI

HEALTH HISTORY FORM Academic Year 2021-2022

{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 <u>other</u> 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:** _____