

EL CAPITAN STUDENT HEALTH HISTORY

Student Name: _____ Sex: M F Birth date: _____

Father: _____ phone: _____ Mother: _____ phone: _____

Emergency Contact: 1st _____ phone: _____ 2nd _____ phone: _____

Has your child ever had injury or illness requiring surgery? Yes ___ No ___ If yes, Please explain below.

Medical Condition _____

Does your child have any of the following conditions?

YES NO

____ *HAD CHICKEN POX?* What age? _____.

____ *ALLERGIES* (i.e., food, medicine, bee stings.) List Allergy _____

Is EPI-PEN prescribed? IF YES, Please speak to nurse. Child will need one at school).

Note: (Nurse must have documentation from MD for any modifications in diet for allergies or other).

____ *ASTHMA* List medications taken for asthma _____

Is *INHALER Prescribed?* (IF YES, Please speak to nurse. Child will need one at school).

____ *DIABETES* When was it diagnosed? _____ Doctor _____

Is *INSULIN needed at school?* When? _____ Type? _____

____ *HYPOGLYCEMIA* is a snack needed at school? Yes NO

____ *ANOREXIA* Require professional assistance? Yes NO

____ *HEAD INJURIES* when? _____ number of ? _____

____ *SEIZURES?* Date of last seizure _____ On Medication? _____

____ *SLEEP PROBLEMS?* Describe _____

____ *EAR PROBLEMS* *Frequent ear infections?* YES/NO Tubes in ears? YES?NO _____

Are hearing aids needed? YES/ NO Does he/she require sitting close to the speaker? YES/ NO

____ *FREQUENTLY SICK?* Strep throat? Kidney infection? High fevers? (Circle those that apply)

____ *RHEUMATIC FEVER* age of child _____ Medication required? _____

____ *ANEMIA* What age? _____ Re-occurring? _____

____ *ADD/ADHD age diagnosed?* _____ Is medication needed at school? _____

List current medication _____

____ *BONE/JOINT PROBLEMS OR FRACTURES* Is a brace required? YES/NO

What bone or joint and when? _____ Left / Right

____ *DEPRESSION* How long? _____ List medication taken: _____

____ *EMOTIONAL CONCERNS* _____

Required Vaccine Doses

Age	DTaP	Polio	Hib	Hepatitis B	Hepatitis A	MMR	Varicella
Preschool	#4	#3	#4	#3	#1	#1	#1
K - 12	#4 or #5	#3 or #4		#3		#2	#1 or #2

CHECK ONE:

- ____ Copy of current official documented immunization record attached.
- ____ Religious Beliefs exemption form signed by parent/guardian attached.
- ____ Medical Exemption form signed by physician and parent/guardian attached.
- ____ Signed Laboratory Proof of Immunity form attached.

Please mark the medications you child may take at school if needed:

- ___ Tylenol ___ Motrin ___ Cough Syrup/Drops ___ Sore Throat Lozenges
- ___ Salves/Ointments ___ Eye Drops ___ Sinus Decongestant ___ Pepto Bismol/ Peppermint/Tums
- ___ No; I do not want my child to receive medication at school.

Students will not receive medication at school unless this paper is signed and on file. You will be required to pick up your student if medication is needed. If student needs medication for extended time or for a chronic condition you must supply the medication and complete a separate form.

Your signature is an informed consent to share this history information with school staff on a need to know basis for Academic success and emergency plans as determined by the school nurse.

Parent Signature: _____ Date: _____

Reviewed by Health Provider: _____ Date: _____