

EI-Capitan K-12 School Student Health History

Student Name _____ Sex: M F Birth Date: _____

Father: _____ Mother: _____ Phone: _____

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

Has your child had any of the following conditions?

YES NO

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

___ ___ **Is EPI-PEN Prescribed? (IF YES, Please speak to nurse. Child will need one for school use).**

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 for school use)**

___ ___ **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

___ ___ **EXCESSIVE HEADACHES-** How often? _____

___ ___ **HEAD INJURIES-** When? _____ # of? _____

___ ___ **LOSS OF CONSCIOUSNESS-** When? _____ Age? _____ How Long? _____

___ ___ **SLEEP PROBLEMS-** Frequent ear infection? YES / NO Tubes? YES / NO

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

___ ___ **FREQUENT HIGH FEVERS-** explain? _____

___ ___ **FREQUENT KIDNEY INFECTIONS-**Care provided? _____

___ ___ **STREP THROAT INFECTION-** Care provided? _____

___ ___ **RHEUMATIC FEVER-** Age of child? _____

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

___ ___ **BONE/JOINT PROBLEM OR FRACTURES-** Is a brace required? YES / NO

What bone or joint and when? _____ Left / Right

___ ___ **ADD or ADHD-** When was diagnosis? _____ Is medication needed at school? _____

List current medication _____

___ ___ **EMOTIONAL CONCERNS-** _____

___ ___ **DEPRESSION-** How long? _____ List medications taken: _____

___ ___ **OTHER-** Describe _____

Please mark the medications your child can take at school from the nurse.

___ Tylenol ___ Ibuprofen ___ Cough Syrup/Drops ___ Sore Throat Lozenges

___ Salves/Ointments ___ Eye Drops ___ Sinus Decogestant ___ Pepto/Tums

___ **No;I do not want my child to receive medications at school.**

Students will not receive medication at school unless this paper is signed and on file. Students without signed permission will be sent home if medication is needed. If your child needs such medication for an extended time for a chronic condition you must supply the medication and complete a separate form.

Immunization History (If claiming Immunization Exemption please see separate form.)

DTaP/ Td									
IPV/O PV									
MMR									
HiB									
Hep B									
Hep A									
Varice lla									
Other									

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: _____