Health Services use only:
*Reviewed/Entered by:*_____
Parent Contacted: _____
Orders on file:

STUDENT HEALTH HISTORY

To be completed by parent/ guardian

Name of Student: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

☐ No ☐ Yes **Glasses/Contacts**, Date of last eye evaluation _____

☐ No ☐ Yes **Hearing aids**, Date of last hearing exam: _____

Primary Doctor: _____ **Dentist:** _____ **Date of last dental visit:** _____

Daily Medications

If your child will need to take medication at school (prescription &/or over-the-counter), they MUST have a Medication Consent Form on file. These forms are available online or in the Front Office.

☐ No ☐ Yes **Medication needed at school** (list): _____
☐ No ☐ Yes **Medication needed at home** (list): _____
☐ No ☐ Yes **Allergies** (list):_____

Life Threatening Medical Conditions

Life-threatening Medical Conditions would be a condition that would put the student in danger of death during the school day. The student must have Emergency Action Plan filled out by his/her healthcare provider.

Life Threatening Conditions (Requires Health Care Provider Orders)
Please check all that apply:

☐ No ☐ Yes **Severe Allergic reaction to Nuts (list):** _____
☐ No ☐ Yes **Severe Allergic reaction to Bee Stings requiring emergency medication:** _____
☐ No ☐ Yes **Other Severe Allergies-affecting school. Specify:** _____
☐ No ☐ Yes **Severe Asthma: <u>regularly takes</u> medication for asthmatic condition and/or hospitalized within the last 5 years for asthmatic condition** _____
☐ No ☐ Yes **Diabetes**
☐ No ☐ Yes **Seizure Disorder that requires an emergency medication:** _____

Health Concerns (potentially life threatening conditions that may require Health Care Provider orders)
Please check all that apply and explain:

☐ No ☐ Yes **Asthma: takes medication only when needed:** _____
☐ No ☐ Yes **Seizure: Type of Seizures and date of last Seizure**: _____
☐ No ☐ Yes **Heart Condition**: _____
☐ No ☐ Yes **Behavioral/Emotional Concerns**: _____
☐ No ☐ Yes **Other Health Concerns**: _____
☐ No ☐ Yes **Any Chronic or recurring illness:** _____

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?
☐ No ☐ Yes if yes, explain: _____

All health information is considered confidential. It may be shared with staff as needed during the time your child is enrolled in East Mills School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature _____ **Date** _____