



**STUDENT HEALTH INFORMATION**  
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ANY SIGNIFICANT BIRTH HISTORY/BIRTH COMPLICATIONS (please explain): \_\_\_\_\_

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**CURRENT/PAST HEALTH HISTORY:**

PLEASE CHECK ANY THAT APPLY TO YOUR CHILD AND EXPLAIN BELOW

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Allergies* (see next page) | <input type="checkbox"/> Headache/Migraines        |
| <input type="checkbox"/> Head injury         | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Neurological Disorder (s) |
| <input type="checkbox"/> Asthma* (see below) | <input type="checkbox"/> Fevers/Febrile Seizure     | <input type="checkbox"/> Ear Infections/Tubes      |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Strep Throat/Sore Throats  | <input type="checkbox"/> Bleeding Disorders        |
| <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Psychiatric History       |
| <input type="checkbox"/> Stomach Aches       | <input type="checkbox"/> Heart Murmur/Condition     | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Skin/Rashes         | <input type="checkbox"/> Bone/Joint Conditions      | <input type="checkbox"/> Urinary Tract Infections  |
| <input type="checkbox"/> Eating Issues       | <input type="checkbox"/> Bowel/Bladder Problems     | <input type="checkbox"/> Tourette's/Tics           |

Comment(s) on any of the above: \_\_\_\_\_

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FOR CHILDREN WITH ASTHMA: Please list known asthma triggers: \_\_\_\_\_

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DOES YOUR CHILD USE AN INHALER AT HOME? YES \_\_\_\_\_ NO: \_\_\_\_\_ HOW OFTEN?: \_\_\_\_\_

WILL YOUR CHILD REQUIRE AN INHALER AT SCHOOL? YES \_\_\_\_\_ NO: \_\_\_\_\_

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**ALLERGY INFORMATION**

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING (Please check all that apply):

**MEDICATIONS(s):** YES \_\_\_\_\_ NO \_\_\_\_\_ if yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**FOOD(s):** YES \_\_\_\_\_ NO \_\_\_\_\_ if yes, please explain: \_\_\_\_\_

\_\_\_\_\_

THE FOOD ALLERGY REACTION OCCURS FROM (check all that apply):

Eating the food(s) listed above (Ingestion):      YES \_\_\_\_\_ NO \_\_\_\_\_

Touching the food(s) listed above (tactile):      YES \_\_\_\_\_ NO \_\_\_\_\_

Smelling the food(s) listed above (inhalation):      YES \_\_\_\_\_ NO \_\_\_\_\_

MY CHILD MAY SIT AT THE SAME TABLE WITH CHILDREN EATING THE FOOD(S) LISTED ABOVE:

YES \_\_\_\_\_ NO \_\_\_\_\_

**BEES or other INSECTS:** YES \_\_\_\_\_ NO \_\_\_\_\_ if yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**ENVIRONMENTAL/SEASONAL:** YES \_\_\_\_\_ NO \_\_\_\_\_ if yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**ANIMALS:** YES \_\_\_\_\_ NO \_\_\_\_\_ if yes, please explain: \_\_\_\_\_

**OTHER ALLERGIES** (please list): \_\_\_\_\_

DOES/WILL YOUR CHILD HAVE AN EPI-PEN FOR USE AT SCHOOL?      YES \_\_\_\_\_ NO \_\_\_\_\_

HAS YOUR CHILD EVER REQUIRED ADMINISTRATION OF AN EPI-PEN?      YES \_\_\_\_\_ NO \_\_\_\_\_

DOES YOUR CHILD TAKE ANY OTHER MEDICATION (S) FOR THE ABOVE NOTED ALLERGY? YES \_\_\_\_\_

NO \_\_\_\_\_ if yes please explain: \_\_\_\_\_

\_\_\_\_\_

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**ADDITIONAL INFORMATION:**

DOES YOUR CHILD TEND TO BE ANXIOUS IN NEW SITUATIONS OR TRANSITIONS? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, DOES YOUR CHILD HAVE ANY CALMING MEASURES? (please list) \_\_\_\_\_

Incidents such as the birth of a sibling, serious accidents or illnesses, death, separation or divorce often affect a child's behavior in school. Feel free to comment in the space provided below or indicate a desire to speak privately with a staff member about any emotional issues or concerns.

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**PARENTS ARE ASKED TO MAKE AN APPOINTMENT TO SPEAK TO THE SCHOOL NURSE  
REGARDING ANY SIGNIFICANT HEALTH ISSUES OR CONCERNS.  
PLEASE CHECK THE APPROPRIATE BOX BELOW:**

\_\_\_\_\_ YES, I WOULD LIKE A PERSONAL APPOINTMENT WITH THE SCHOOL NURSE

\_\_\_\_\_ NO, I DO NOT NEED TO SPEAK WITH THE SCHOOL NURSE

\_\_\_\_\_  
Parent /Guardian (Print Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (Signature)

\_\_\_\_\_  
Phone/Contact