Student Health History

JACKSON R-2 PUBLIC SCHOOLS

For your child to gain the most from his/her education, it is important for the school nurse to have a current health history. Please complete or update the following information:

School _____ Grade _____

Full Name _____ Birth date _____ Male/Female _____ Race _____

TYPE OF INSURANCE: None ☐ Private Insurance ☐ Medicaid or/MC+ ☐ Preferred Hospital _____

DATE OF LAST PHYSICAL EXAM _____ Doctor/Clinic _____

DATE OF LAST DENTAL EXAM _____ Dentist _____

Is your child under an orthodontist's care? YES ☐ NO ☐ Orthodontist Name _____

My child has the following health concerns:

EYES: glasses ☐ for reading ☐ for distance ☐ contacts ☐ lazy eye ☐ difficulty seeing ☐ surgery ☐

Other (explain) _____

EARS: frequent infections ☐ tubes ☐ date inserted _____ hearing difficulty (explain)_____

Hearing aid - Right ☐ Left ☐ Wear to school? YES ☐ NO ☐ Other (explain)_____

ALLERGIES: (drugs, food, insects, pollens) Please list: _____

Has allergy required emergency action in the past? YES ☐ NO ☐ Describe reaction: _____

_____ Treatment: _____

ASTHMA: YES ☐ NO ☐ Doctor treating asthma: _____

***If you answered "yes", please see the school nurse to complete an Asthma Needs Assessment.**

SEIZURES: YES ☐ NO ☐ Describe Seizure _____

Doctor treating seizures: _____ Date of last seizure: _____

Medication: _____

***If you answered "yes" - please see the school nurse to complete a Seizure Action Plan.**

DIABETES: YES ☐ NO ☐ Doctor treating diabetes: _____ Medication:_____

_____

***If answered "yes" – please see the school nurse to complete a Diabetic Action Plan.**

ATTENTION DEFICIT DISORDER (ADD/ADHD): YES ☐ NO ☐ Medications taken at home: _____

_____ Medications taken at school: _____

***If your child requires medication at school, please obtain a Request for Administering Medication form from the school nurse.**

OTHER HEALTH CONCERNS: heart problems ☐ bleeding ☐ eating ☐ sleeping ☐ bowel ☐ nosebleeds ☐ bladder ☐ dental ☐ skin ☐ menstruation ☐ phobias (fears) ☐ blood pressure ☐ lungs ☐ orthopedic ☐ neurologic ☐ headaches ☐ blood disorder ☐ Explain: _____

OTHER MEDICATIONS: List all daily medications taken at home and reason for taking: _____

_____

List all medications taken at school and reason for taking: _____

List other serious illnesses or injuries: _____

List any surgeries: _____

List any special procedures your child would need at school (catheter, tube feeding, etc.):_____

_____

Does your child have a medical diagnosis that the school nurse should be aware of at this time? (PDD, Chromosome Disorder, etc.) _____

_____

_____

I hereby give authorization for the school nurse, or other school employee under the direction of the school nurse, to administer over-the-counter medications. It is my responsibility to notify the school nurse of any allergies to certain medications or changes in my child's health during the school year.

_____ _____

Parent's Name Date

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