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: (Please Circle One) None Private Insurance Medicaid or/MC+

Preferred Hospital _____

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: _____

***If you answered "yes", please contact the school nurse.** Treatment: _____

ASTHMA: YES □ NO □ Doctor treating asthma: _____

Medication: _____

***If you answered "yes", please contact the school nurse.**

SEIZURES: YES □ NO □ Describe Seizure _____

Doctor treating seizures: _____ Date of last seizure: _____

Medication: _____

***If you answered "yes", please contact the school nurse.**

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

_____

***If answered "yes", please contact the school nurse.**

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

_____ Medications taken at school: _____

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: _____

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

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