Print Form

STUDENT HEALTH HISTORY – CONTINUED on the back.

NEUROLOGICAL		COMMENTS	GASTROINTESTINAL/ GENITOURINARY		COMMENTS
CEREBRAL PALSY	☐		BLADDER CONTROL PROBLEMS Explain:	☐	
SEIZURE DISORDER	☐	Date of last seizure: **Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	URINARY TRACT INFECTION Frequency:		Date of last infection:
MIGRAINE Frequency:	☐	Date of last migraine: **Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	BOWEL CONTROL PROBLEMS Explain:	☐	
SPINA BIFIDA	☐		**DENTAL**	✓	
SLEEP DISORDER	☐		BRACES	☐	
HEADACHES Frequency:	☐		CAVITIES Date of last dental exam:		
PSYCHIATRIC	✓		CANKER SORES		
ATTENTION DEFICT (HYPERACTIVITY) DISORDER ADD/ADHD	☐	**Date of diagnosis:** **Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	**NUTRITION METABOLIC**	✓	
DEPRESSION Date of diagnosis:	☐	**Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	NUTRITIONAL PROBLEMS Explain:	☐	
AUTISM	☐		OVERWEIGHT/OBESE	☐	
SUICIDAL, History of	☐	Date:	POOR APPETITE	☐	
SUBSTANCE ABUSE, History of	☐	Circle: Drugs, alcohol, tobacco, and/or inhalants Date:	**MISCELLANEOUS**	✓	
ANOREXIA	☐		THUMBSUCKING	☐	
BULIMIA	☐		MOTION SICKNESS	☐	

MEDICATION AND HOSPITALIZATION

DOES YOUR CHILD NEED TO TAKE DAILY MEDICATIONS AT SCHOOL? A Medication During School Hours form **MUST** be signed by a physician and a parent and **MUST** accompany prescribed medications. All medications taken at school **MUST** be maintained and administered from the health office under supervision of school personnel. SPECIFY ALL CURRENT MEDICATIONS *(including medications taken at home)*:	YES ☐ NO ☐	Comments
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of hospitalization: _____ Reason: mo./day/yr.	YES ☐ NO ☐	Comments

SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS
(PLEASE PRINT)

PRIVACY ACT NOTICE

AUTHORITY: Title X, Section 133 7 1076, Title V, Section 301. PRINCIPAL PURPOSE: To record pertinent data concerning student's health. ROUTINE USES: Data is collected and entered into the automated Health Office Management System for use by professional health and education agencies. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NONDISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature: | **Date:**