



HEALTH AND WELLNESS SERVICES

Personal Health History 2018-19

Student Name: _____ Student ID: _____ Gender: ___ DOB: _____ Gr: ___
Address: _____ City: _____ State: _____ Zip: _____

Notification Phone #1: _____ [] Emergency Only Head of Household #1
Name: _____ Relationship to Student: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____
Notification Phone #2: _____ [] Emergency Only Head of Household #2 (If applicable)
Name: _____ Relationship to Student: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

IN CASE OF ILLNESS OR EMERGENCY, FIRST CONTACT IS MADE TO THE PARENT(S)/GUARDIAN. Please list two contacts other than parents for emergencies.
Name: _____ Relationship to Student: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____
Name: _____ Relationship to Student: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Information for School Personnel
[] My child has no medical problems that impact the school day.
For those with health conditions, please list any medication your child is currently taking.
Medication _____ Dose _____ Time _____
Is physical activity restricted? [] YES [] NO
If yes, please explain: _____
Does the student have a 504? [] YES [] NO
Does the student have an IEP? [] YES [] NO
[] I believe my child's medical condition(s) substantially limits one or more of his/her major life activities.
Child's Primary Physician: _____
Physician's Phone Number: _____
Insurance [] Private [] Medicaid/HHW [] None
Has your child been hospitalized in the last year? [] YES [] NO
If yes, please explain: _____



HEALTH AND WELLNESS SERVICES

Personal Health History 2018-19

Please list any severe life threatening allergies that require medication

Please list specifics

- Food, Insect/Bees, Medications, Other, Needs Epi-pen

Please check the boxes if your child has any of the following issues

- ADD/ADHD, Head Injury/Concussion, Lung Disease, History TB, Migraines with prescription medication, Psychological/Psychiatric, Allergies non-life threatening, Asthma, Autism, Sickle Cell, Cancer, Diabetes, Special procedures needed, Other

Individual Health Plans should be in place for students with conditions like Asthma, Diabetes, Seizures and Severe Allergies. Some of these health plans require the signature of a physician. To insure the safety of your child, please contact your school nurse as soon as possible to complete these plans.

For internal use only

- Care plan sent to parent for completion, Care plan returned to school

To ensure the care of my child, I read and agree that pertinent health information be provided to appropriate school staff. This will be done only on a 'need to know' basis, in a confidential manner. I agree that the school nurse may consult with my child's family physician(s) about the above medical condition(s). I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of the child. I will furnish the school with a current telephone number and address in case of an emergency. The above permission will be valid for one year from the date below, unless I revoke the permission in writing. In case of an emergency involving your child, it is the policy of this school cooperation to call a doctor, and only in extreme cases will your child be taken to the hospital.

Parent/Guardian Name Date