HEALTH AND WELLNESS SERVICES

Personal Health History 2016-17

Student Name: _____ _____ **Gender M/F**:_____ **Birth Date**:_____ **Grade**:_____
(Last) *(First)*

Address: _____ **City**: _____ **Zip Code**: _____

Home Phone: _____ **Student lives with**: _____

Father's Name: _____ **Employer**: _____

Father's Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Mother's Name: _____ **Employer**: _____

Mother's Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

IN CASE OF ILLNESS OR EMERGENCY, FIRST CONTACT IS MADE TO THE PARENT(S). Please list two contacts other than parents for emergency situations.

#1 Name: _____ **Phone**: _____ **Relationship**: _____

#2 Name: _____ **Phone**: _____ **Relationship**: _____

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

Please list any severe/life threatening allergies that require medication

Please list specifics

❑Food ❑Needs Epi-Pen _____
❑Insect/Bee ❑Needs Epi-Pen _____
❑Medications ❑Needs Epi-Pen _____
❑Other _____

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

❑ADD/ADHD
❑Allergies non-life threatening
Describe_____
❑Asthma ❑has inhaler
❑Autism
❑ Cystic Fibrosis
❑ Cancer Type _____
❑Diabetes ❑Type I ❑Type II
❑Head Injury/Concussion
❑Lung Disease ❑History TB .
❑ Migraines with prescription medication
❑ Psychological/Psychiatric _____
❑ Seizure Disorder ❑ needs Diastat
❑ Sickle Cell ❑disease ❑trait
❑Special procedures needed_____
❑ other _____

Is physical activity restricted? ❑❑**Yes** ❑❑ **No**

If yes, in what way? _____

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

Reason? _____

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 Date_____
❑Care plan returned to school Date_____

To ensure the care of my child, I read and agree that pertinent health information may 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 my 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 corporation to render first aid treatment while contacting parents for further instructions. Only after reasonable efforts to reach the parents without success will we call a doctor, and only in extreme cases will your child be taken to a hospital or 911 contacted.

Parent / Guardian Signature_____**Date** _____