HEALTH HISTORY UPDATE

NOTICE TO PARENTS/GUARDIANS:

Please complete this form and return to the school nurse at start of school year. This form is confidential.

Student's Name: ____

Date of Birth: ___________________________ Grade: ____

Doctor: ___________________________________ Doctor's office number: _________________________

1. Current health problems: ____
2. Past medical history: ____
3. Hospitalizations: ____
4. Recent surgery: ____
5. Mental health history (anxiety, depression, eating disorder): __________________________________
6. Concussion history: ____
7. Allergies and reactions: ____
8. Treatment required for allergic reaction: _____ Epi Pen / Auvi-Q _____ antihistamine _____ inhaler

(please indicate specific medications on attached medication consent form)

9. History of asthma: _____No _____Yes _______ inhaler: _____________________________________
10. Health care needs while at school: ____
11. Daily medications: ____
12. History of communicable disease (chicken pox, Pertussis): __________________________________
13. Date of last physical exam: __________ Significant findings: _________________________________
14. Date of last dental exam: ___________ Significant findings: _________________________________
15. Date of last eye examination: _________ Significant findings: _______________________________

Please provide the school nurse with a copy of your daughter's immunization record any time she receives additional vaccinations. Please have medication consent form signed by yourself and a licensed prescriber.

Thank you for providing this information to ensure the best care for your daughter.

DATE: ___________________Signature: ____