

Knowlton Township Elementary School

School year: _____

Health History Form

Student name
Date of birth
Grade

Part I: Student Health Status

Complete the following checklist by indicating any of the following conditions, past or present. Include a separate sheet of paper if additional detail is necessary.

Condition	Yes	No
Heart problem/ defect		
ADD/ ADHD		
Anemia (include sickle cell)		
Arthritis		
Back/Neck Injury or condition		
Blood/ Clotting Disorder		
Cancer/ Leukemia		
Diet Restrictions		
Head Injury/ Concussion		
Headaches		

Condition	Yes	No
Hearing deficit (explain correction below)		
Hepatitis		
Surgery		
Activity restrictions		
Physical disability		
Mononucleosis		
Epilepsy		
Vision deficit (explain correction below)		
Other: (explain below)		

Please give details for all that are marked **YES** above: _____

Does your child have asthma? Yes No If yes, medications taken: _____
 Mild Moderate Severe

Does your child have allergies? Yes No Nature of allergy: _____
 Mild Moderate Severe EpiPen prescribed? Yes No

Does your child have diabetes? Yes No If yes, insulin, glucometer and care needed at school: _____

Does your child have seizures? Yes No If yes, describe type and meds taken: _____

Part II: Current Medications

Does the student take any medication (prescribed and/or OTC)? Yes No Explain. Include dosage, reason and frequency:

Is medication required during school hours? Yes No If yes, please obtain necessary form at registration or from the nurse.

Part III: Consents and Signatures

Yes No **CONSENT TO CONTACT DOCTOR:** The School Nurse has permission to contact my child's doctor if medically necessary.

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that medications of any kind are not allowed on school grounds without the proper medical authorization on file. I understand that school staff, including the nurse, MAYNOT administer or assist with any medications without the proper medical authorization on file.

I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information shared, I must request this in writing and file it with the school nurse.

Parent/Guardian signature

Date