



HEALTH AND WELLNESS SERVICES

Personal Health History 2018-19

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

Notification Phone #1: _____ <input type="checkbox"/> Emergency Only	Notification Phone #2: _____ <input type="checkbox"/> Emergency Only
Head of Household #1	Head of Household #2 (If applicable)
Name: _____	Name: _____
Relationship to Student: _____	Relationship to Student: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell 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: _____	Name: _____
Relationship to Student: _____	Relationship to Student: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell 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.

<u>Medication</u>	<u>Dose</u>	<u>Time</u>

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: _____



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Please list any severe life threatening allergies that require medication

Please list specifics

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Food | <input type="checkbox"/> Needs Epi-pen _____ |
| <input type="checkbox"/> Insect/Bees | <input type="checkbox"/> Needs Epi-pen _____ |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Needs Epi-pen _____ |
| <input type="checkbox"/> Other | <input type="checkbox"/> Needs Epi-pen _____ |

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

- | | | | | |
|-----------------------------------|---|---------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> History TB | <input type="checkbox"/> Migraines with prescription medication |
|-----------------------------------|---|---------------------------------------|-------------------------------------|---|
- Psychological/Psychiatric
Describe: _____
- Allergies non-life threatening
Describe: _____
- Asthma Has inhaler YES NO
- Autism Cystic Fibrosis Seizures Needs Diastat
- Sickle Cell Disease or Trait
- Cancer Type: _____
- Diabetes Type I Type II
- 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 Date _____
- Care plan returned to school Date _____

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 _____