PEQUEA VALLEY SCHOOL DISTRICT HEALTH HISTORY

Date:___/___/_____ Last School Child Attended:_____

To Parents/Guardians: The information requested on this form will be of help to the school authorities in determining the health status of your child and in assisting him/her to receive maximum benefits from his educational opportunities.

I understand that the information will be kept confidential by the School Health Staff and will be shared with other professionals in the school and in other institutions only when the school nurse believes that it is in the best interest of my child's health and education.

Student's Name: _____
(First, Middle and Last)

Nickname _____ Gender ☐ M ☐ F Grade _____ Birthdate ____/____/_____ Phone _____

Father: _____ Mother: _____
Check if applicable: ☐ Step ☐ Foster Check if applicable: ☐ Step ☐ Foster

Person with whom student lives if other than above: _____
Check if applicable: ☐ Guardian ☐ Institution ☐ Other

Family Doctor: _____ Family Dentist: _____

Has your child had or now have any of the following?

Severe Allergies? ☐ Bee ☐ Peanut ☐ Tree Nuts ☐ Egg ☐ Milk ☐ Shellfish ☐ Latex ☐ Seasonal

Drug Allergies? (please list) _____ Other Allergies _____

Allergy Treatment Plan (include medication) _____

☐ ADD/ADHD
☐ Diabetes
☐ Ear Infections
☐ Kidney Problems
☐ Heart Condition
☐ Asthma
☐ Vision Loss
☐ Hearing Loss
☐ Emotional Problems
☐ Speech
☐ Orthopedic Disorder
☐ Hearing Aides
☐ Glasses/Contacts
☐ Migraine Headaches
☐ Skin Problem _____
☐ Chicken Pox
☐ Bleeding Problem
☐ Seizure Disorder
Date of last seizure ____/____/_____

Asthma inhaler used at school ☐ Yes ☐ No

List all of your child's medications taken at home and in school (dose, time, and reason):

_____

List any other medical conditions: _____

Restricted from physical activity? (Written restrictions signed by a doctor are required) ☐ Yes ☐ No If yes, describe below:

_____

Special diet and/or have a specific food restriction? ☐ Yes ☐ No Explain: _____

Serious illness, injury, hospitalization or operations: _____

Signature: _____ Date: ____/____/_____

***Proof of immunization is required and all immunizations must be complete before children begin school. Please ask your doctor for written verification if you do not have record of immunizations.**