HOCKINSON SCHOOL DISTRICT

Student Health History 2016-2017

To be completed by parent/guardian (Mark those that apply)

Student Name: _____ Date of Birth: _____ Grade: _____ ☐ Male ☐ Female

Home phone #: _____ Work#: _____ Teacher: _____

Life Threatening Medical Conditions:(check all that apply)State law requires a medication/treatment order from a Licensed Health Professional before your child can attend school if a life threatening condition exists. A form is available from the school office.

☐ Yes ☐ No **SEVERE allergic reaction to Nuts** - specify: _____

☐ Yes ☐ No **SEVERE allergic reaction to Bees** - specify: _____

☐ Yes ☐ No **Other SEVERE allergies-affecting school.** specify: _____

Asthma REQUIRES DAILY medication for asthmatic condition OR has been hospitalized OR had emergency room/urgency care clinic visits within the past year for asthmatic condition.

☐ Yes ☐ No **Diabetes, diagnosed at age:** _____

☐ Yes ☐ No **Medication or food alergies:** _____

☐ Yes ☐ No **Other:** _____

Possible Life Threatening Medical Conditions: (check all that apply)

State law requires a medication/treatment order from a Licensed Health Professional if your child's health condition *will put your child in danger of death during the school day.* Orders must be in place before your child can attend school. A form is available from the school office.

☐ Yes ☐ No **Asthma - takes medication only when needed. Medication:** _____

☐ Yes ☐ No **Seizure Disorder:**

Types of Seizures and date of last Seizure: _____

☐ Yes ☐ No **Heart Condition:** _____

☐ Yes ☐ No **Blood Disorder:** Specify: Hemophilia ☐ Anemia ☐ Other ☐ _____

Does your child have any other diagnosed condition that would affect his/her classroom performance or P.E. activities?

☐ Yes ☐ No If yes, explain: _____

☐ Yes ☐ No **Behavioral / Emotional Concerns:** _____

☐ Yes ☐ No **Attention Deficit Disorder:** Specify: ADD ☐ ADHD ☐ Medication Taken: _____

☐ Yes ☐ No **Orthopedic Condition:** _____

☐ Yes ☐ No **Wears Glasses / Contacts:** Date of Last Eye Evaluation: _____

☐ Yes ☐ No **Wears Hearing Aids:** Date of Last Hearing Exam: _____

Daily Medication

State law requires written permission from a Licensed Health Professional and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

☐ Yes ☐ No **Medication Needed at School** - specify: _____

☐ Yes ☐ No **Medication Needed at Home**- specify: _____

This information is considered confidential. It will be shared with school staff only as needed during the time your child is enrolled inHockinsonSchool Districtin order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature: _____ Date: _____