FAYETTEVILLE CITY SCHOOLS HEALTH SERVICES *Confidential*
HEALTH HISTORY

THIS FORM MUST BE COMPLETED BY A PARENT OR GUARDIAN

Dear Parents/Guardians, Date: _____

Please complete the information on your child's health history. This information is needed in order that we may give your child the best possible care in the event of an illness or emergency. If your child does have a health condition/concern PLEASE give detailed information about what is needed to give your child the best possible care.

Student Name_____ Grade/Teacher_____
first middle last
Date of Birth_____ Age_____ Sex M or F Physician_____
Legal Guardian_____
Address_____
Father's Name_____ Father's Home Phone_____
Father's Work Phone_____ Father's Cell Phone_____

Mother's Name_____ Mother's Home Phone_____
Mother's Work Phone_____ Mother's Cell Phone_____

Brothers and sisters at school (names and homerooms)_____

ATTEMPTS WILL BE MADE TO CONTACT A PARENT FIRST IN CASE OF ILLNESS OR EMERGENCY. IF A PARENT CANNOT BE REACHED, PLEASE LIST EMERGENCY CONTACTS IN THE ORDER YOU WISH FOR THEM TO BE CONTACTED.

1. Name_____ Phone_____ Relationship_____

2. Name_____ Phone_____ Relationship_____

3. Name_____ Phone_____ Relationship_____

HEALTH INFORMATION

1. Is the student under medical treatment at this time? Yes_____ No _____ If yes, please describe including a list of all medications given at home._____

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2. Has the student had any serious injuries, illnesses, accidents or been hospitalized recently? Yes_____ No_____ If yes, please describe_____.

3. Is the student required to have daily medications or medical treatments during school hours? This includes asthma inhalers, breathing treatments, injections, topical creams and oral medications. <u>These require a medication consent form</u> (attached). Please list all medications and treatments below.
1._____
2._____
3._____

please complete reverse

4**. IS CHILD ALLERGIC TO ANY OF THE FOLLOWING:**

Foods_____ Reaction_____ Treatment_____
(Requires a physician statement to be sent to school)

Medications_____ Reaction_____ Treatment_____
Insects_____ Reaction_____ Treatment_____
Chemicals_____ Reaction_____ Treatment_____
Seasonal Allergies_____ Reaction_____ Treatment_____
If you would like for your child to be given the above listed treatment, complete and return the medication consent form.

5. Does student require any of the following: (please mark all that apply)
Glasses _____ Contact lenses _____ Hearing aid _____ Wheelchair _____ Crutches _____
Artificial limbs _____ Other (describe) _____

6. Health Problems: Please mark all that apply and describe the health problem(s) along with any medication or treatment needed.

_____ADD/ADHD
_____ASTHMA/BREATHING PROBLEMS
_____AUTISM
_____BOWEL/INTESTINAL PROBLEMS
_____ CARDIAC/HEART PROBLEMS
_____ CANCER/LEUKEMIA
_____ DENTAL PROBLEMS
_____ DIABETES/HYPOGLYCEMIA
_____ EPILEPSY/SEIZURES/CONVULSIONS
_____ HEADACHES - frequent requiring medication
_____ HEADACHES -MIGRAINE
_____ HEADACHES -SINUS
_____ HEARING IMPAIRMENT
_____ HEMOPHILIA/BLEEDING DISORDER
_____HYPERTENSION/HIGH BLOOD PRESSURE
_____ LEARNING DISABILITY
_____ NEUROLOGICAL/BIRTH DEFECT
_____ PHYSICAL IMPAIRMENT
_____ SICKLE CELL ANEMIA
_____ SKIN DISORDERS
_____ STOMACH PROBLEMS/ULCERS
_____ URINARY/KIDNEY/BLADDER PROBLEMS
_____ VISION PROBLEMS
_____OTHER (PLEASE LIST)

Explanation of health problems marked above_____

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7. Does the student have any limitations that prevent him/her from participating in physical education or school sponsored activities? If so, please describe and send a physician statement regarding limitations.

_____

8. Please describe any special health needs/services your child may require at school

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_____

9. Any additional comments_____

I give consent _____, do not give consent _____ for my child to receive basic first aid at school for minor injuries, insect bites or small accidents that occur. Injuries will be cleaned with soap and water. At times hydrogen peroxide, antibiotic ointment and anti-itch creams may be used if necessary.

I give consent _____, do not give consent _____, for my student's vision and hearing to be screened if needed.

Parent's signature Date

I have read and understand the medication policy_____
Parent's signature Date