

ROBERTSON COUNTY SCHOOLS STUDENT HEALTH HISTORY

Dear Parent/Guardian, please complete the following information so we may update your child's confidential health record. **Please PRINT.** Respond to questions on the back of the form if needed. Return this form to the School Nurse as soon as possible, so we may best meet your child's needs. Thank you.

Student Name: _____ DOB: _____ Grade/Teacher: _____

Home Address: _____ Phone Number: _____

Parent Email Address: _____

1. Any significant injury such as concussion, fracture, dislocation, etc.? YES NO

If yes, what & when? _____

2. Any significant illness or condition (ADD, ADHD, Asthma, Diabetes, Seizures, etc.)?..... YES NO

If yes, what? Medicine or procedures needed at school? _____

3. Currently taking medications? If yes, what? _____ YES NO

4. Any episodes of fainting, loss of consciousness, or dizziness? YES NO

If yes, when, where, why, and treatment? _____

5. Any surgery or hospitalization? If yes, when & why? _____ YES NO

6. Currently under a doctor's care? If yes, for what? _____ YES NO

7. Any emotional concerns? If yes, what? _____ YES NO

8. Any significant allergies (food, insects, medications, etc.)?..... YES NO

If yes, what are they allergic to and what is the reaction: _____

If an EpiPen is prescribed, parent must provide EpiPen, doctor's order, and sign consent forms at school.

9. Does the student wear: Contacts? YES NO Glasses? YES NO

Dentures/Partial? YES NO Bridge Work? YES NO

10. Any hearing problem? If yes, describe: _____ YES NO

Does your child use hearing aids or other devices: _____

11. Do you know any reason why your child should not participate in Physical Education (PE) or Sports? YES NO

12. Any recent immunizations? **If yes, please provide school nurse a copy.**..... YES NO

Name of Student's Doctor _____ Phone # _____ Fax # _____

Emergency Contacts: 1) _____ Home# _____ Work# _____ Cell# _____

PLEASE PRINT

2) _____ Home# _____ Work# _____ Cell# _____

3) _____ Home# _____ Work# _____ Cell# _____

If your child requires medications at school, please contact school nurse for forms. This includes inhalers for asthma and EpiPens for severe allergic reactions. The only meds your child may carry with them at school are inhalers and EpiPens, if he/she is developmentally appropriate and **the doctor has authorized.** Students cannot carry any other medications. **All prescription meds require a doctor's order and parental consent. Over-the-counter meds only require a parental consent.**

HEALTH HISTORY INFORMED CONSENT: Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature also gives informed consent to share your child's information with school staff and healthcare providers on a need-to-know basis for care/emergency plans.

Parent/Guardian Signature _____ Date _____ Phone# _____

Parent Name Printed: _____