

## STUDENT HEALTH HISTORY UPDATE 2024-2025

*This information will be shared with staff, administration and emergency medical staff on a need to know basis unless you notify us otherwise.*

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Student \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ Grade \_\_\_\_\_

**PLEASE CHECK IF YOUR CHILD HAS OR HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.**

- |  |  |                                      |  |
|--|--|--------------------------------------|--|
| 1. <input type="checkbox"/> ADD/ADHD     | <input type="checkbox"/> Bone/Spine    | <input type="checkbox"/> Ear/Hearing | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Emotional   | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Eye/Vision  | <input type="checkbox"/> Speech              |
| <input type="checkbox"/> Behavior issues | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart       | <input type="checkbox"/> Surgery             |
| <input type="checkbox"/> Blood Disorder  | <input type="checkbox"/> Kidney        | <input type="checkbox"/> Infections  | <input type="checkbox"/> Other _____         |

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does your child have allergies to medicine, food, latex or insect bites?  
Yes ( ) No ( ) To what \_\_\_\_\_ What happens \_\_\_\_\_  
Treatments \_\_\_\_\_

3. Has your child had any illnesses or general health concerns in the last 12 months?  
Yes ( ) No ( ) Type of illness/health concern and date(s) \_\_\_\_\_  
Did your child see a doctor for this or receive medication or treatment?  
Yes ( ) No ( )  
Comments \_\_\_\_\_

4. Has your child had surgery in the last 12 months?  
Yes ( ) No ( )  
Type of surgery and date(s) \_\_\_\_\_  
Comments \_\_\_\_\_

5. Does your child take **any** medications (prescriptions or over the counter), or treatments on a regular basis?  
Name of medication/treatment, doses, and time taken \_\_\_\_\_  
\_\_\_\_\_  
Will these medications be taken during school hours?  
Yes ( ) No ( ) \*If yes, please contact the school nurse.  
When was your child last seen by the doctor concerning these medications? \_\_\_\_\_

6. Does your child receive any treatments? \_\_\_\_\_ For? \_\_\_\_\_

7. When was your child's last physical exam (including immunization review)? \_\_\_\_\_  
Name of child's primary healthcare provider \_\_\_\_\_

8. Has your child had any emotional upsets in the past 12 months (death, separation, divorce or recent move)?  
Yes ( ) No ( ) Comments \_\_\_\_\_  
\_\_\_\_\_

9. Does your child wear corrective lenses or glasses? Yes ( ) No ( ) Date of last exam \_\_\_\_\_  
Name of doctor? \_\_\_\_\_

10. Does your child have any dental problems? Yes ( ) No ( ) Date of last exam \_\_\_\_\_  
Name of doctor? \_\_\_\_\_