

HEALTH HISTORY FORM

This form should be filled out by the child's parent or legal guardian. Return the completed to your child's school nurse.

Name of Child: _____ Date of Birth: _____ Sex: Male Female Grade: _____

MEDICAL HISTORY

Health concerns: Does your child have any health concerns the nurse needs to be aware of? Yes No
If YES, please describe: _____

Can your child participate in all school activities? Yes No

Allergies: Does your child have allergies? Yes No
If YES, what is your child allergic to? _____

Does your child carry an EpiPen? Yes No

Medication: Does your child currently take medications? Yes No
If YES, what medicine? _____

Past medical history: Date of last doctor's visit _____

Does or has your child received medical care of any of the following: No

- | | | | | |
|--|--|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Concussion/Head Injury | <input type="checkbox"/> Other | _____ |

MEDICAL PROVIDER INFORMATION

Primary care provide: Name _____ Clinic/Practice Name _____

Dentist: Name _____ Clinic/Practice Name _____

Optometrist: Name _____ Clinic/Practice Name _____

Families are expected to provide coverage to meet the needs of their student. Families may choose to purchase a supplemental **STUDENT ACCIDENT INSURANCE** through the school. You may obtain applications from School Office. Applications for the **KANCARE are available from your school nurse, health department, and doctor's office or online at <http://www.kancare.ks.gov/index.htm>**

PARENT/GUARDIAN CONSENT

The school nurse has permission to give my child the following **over-the-counter medications**:
We will request parents/guardian to bring medication to be stored in nurse office to be dispensed if we give over 3 dosages during school year.

Please mark or check medications' that approved to dispense by nurse or delegated staff

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen (same ingredient as TYLENOL) | <input type="checkbox"/> Cough Drops |
| <input type="checkbox"/> Ibuprofen (same ingredient as ADVIL) | <input type="checkbox"/> Aloe Vera or Burn Spray for burns |
| <input type="checkbox"/> Triple Antibiotic Ointment | <input type="checkbox"/> Hydrocortisone Cream |
| <input type="checkbox"/> Calamine Lotion or Anti-itch spray for rash | |

VACCINATIONS

Has your child received any recent vaccinations? Yes No
If YES, please list and provide a copy of report: _____

Statement of Consent: This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health of the student. In order to better serve the health needs of my child, I hereby give permission for the transfer of health information to school and other appropriate health professionals, including immunizations status to state and local authorities as requested. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Parent/Guardian Signature: _____ Print Name Here: _____ Date: _____