COUNCIL ROCK SCHOOL DISTRICT

SCHOOL HEALTH SERVICES HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN)

The information provided is confidential. This information is necessary for the health and safety of the student to assist in promoting optimal healthcare to facilitate the academic success of each student. Thank you for your time.

NAME OF CHILD: _____
Last First Middle

ADDRESS: _____
Street City State Zip

HOME PHONE NUMBER: _____ E-Mail address _____

DATE OF BIRTH: _____ Grade _____ MALE: _____ FEMALE: _____

PARENT/GUARDIAN: _____ PHONE: _____
Last First

PARENT/GUARDIAN: _____ PHONE: _____
Last First

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

CHILD'S PHYSICIAN: _____ PHONE NUMBER: _____ DATE OF LAST EXAM: _____

CHILD'S DENTIST: _____ PHONE NUMBER: _____ DATE OF LAST EXAM: _____

LAST SCHOOL ATTENDED: _____

ADDRESS: _____ PHONE NUMBER: _____

DISEASE/DISORDER HISTORY OR ILLNESS
Please check any of the following that apply:

	Yes	No		Yes	No
Allergies/Environmental			**Eating Disorder**		
Allergies/Food			**Endocrine Disorder**		
Allergies/Insect Stings or Bees			**Head or Spinal Injury**		
Allergies/Latex			**Headaches/Migraines**		
Allergies/Medications			**Hearing Problem**		
Allergies/Other			**Heart Defect or Disease**		
Asthma/Breathing Disorder			**Hepatitis or Liver Problem**		
Behavioral Disorder			**Hypertension**		
Bladder/Kidney Disorder			**Immune System Disorder**		
Bleeding/Clotting Disorder			**Mobility Limitation**		
Bone/Joint/Muscular Disorder			**Psychological/Emotional Problem**		
Cancer			**Scoliosis**		
Convulsions/Epilepsy/Seizure			**Skin Condition**		
Developmental Disorder			**Urinary/Bladder/Kidney Disorder**		
Dizziness or Fainting			**Speech Disorder**		
Diabetes			**Surgery or Hospitalization**		
Dietary Restriction			**Vision or Eye Disorder**		
Digestive/Bowel Disorder			**Other (explain below)**		

- Was a medical evaluation performed for any condition/disorder checked 'yes': Yes_____ No_____

Please turn page over and complete the other side

DISEASE/DISORDER HISTORY OR ILLNESS (con't)

My child is under a Doctor's care for Asthma: Yes ☐ No ☐ If yes, medications taken:_____

Emergency inhaler to be prescribed for school: Yes ☐ No ☐

* An *Asthma Action Plan* form will need to be completed by the Doctor and signed by parent to ensure a safe school environment for your child.

My child is under a Doctor's care for a Severe Allergyto _____

Please describe the allergic reaction: _____

Epi-pen prescribed for school: Yes ☐ No ☐

*An *Allergy Action Plan* form will need to be completed by the Doctor and signed by parent to ensure a safe school environment for your child.

My child is under a Doctor's care for Diabetes: Check type: Type 1_____Type 2 _____

*Diabetic Medical Management Plan needs to be completed by your physician and signed by parent

My child is under a Doctor's care for Seizures: Yes ☐ No ☐

If yes, describe type and medications taken: _____

Emergency Seizure medications to be prescribed for school: Yes ☐ No ☐

**Seizure action* plan needs to be completed by student's physician and signed by parent

***** ***All medical forms are available on the district website or from school nurse***

MEDICATION HISTORY

Does your child take medication on a daily basis (include homeopathic and nutritional supplements)? Yes ☐ No ☐

Please list all medications taken and what the medication or supplement is for:

_____

_____

_____

SOCIAL HISTORY

Have there been any changes in your family during the past year, such as:

Separation, divorce, or remarriage? Yes ☐ No ☐

Death or serious illness? Yes ☐ No ☐

Any other situation, which may affect your son/daughter? Yes ☐ No ☐

If yes, please explain:

_____

_____

MISCELLANEOUS

Please list any condition and/or restrictions that your child may have which might limit his/her activities in school. Please include any comments that you think might be helpful:

_____

_____

_____

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers. I understand copies of my child's physical and dental exams will be sent to school within the first week. Please notify the nurse if there are any concerns.

Parent/Guardian Signature:_____Date: _____