

CENTENNIAL 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: _____

FATHER'S (GUARDIAN) NAME: _____ CELL #: _____
Last
First

MOTHER'S (GUARDIAN) NAME: _____ CELL #: _____
Last
First

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	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Food	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Insect Stings or Bees	<input type="checkbox"/>	<input type="checkbox"/>	Head or Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Latex	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Medications	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Other	<input type="checkbox"/>	<input type="checkbox"/>	Heart Defect or Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Breathing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Liver Problem	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Immune System Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Limitation	<input type="checkbox"/>	<input type="checkbox"/>
Bone/Joint/Muscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Emotional Problem	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Epilepsy/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Urinary/Bladder/Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Speech Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Surgery or Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Dietary Restriction	<input type="checkbox"/>	<input type="checkbox"/>	Vision or Eye Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Digestive/Bowel Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other (explain below)	<input type="checkbox"/>	<input type="checkbox"/>

- 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: _____

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

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

Please describe the allergic reaction: _____

Epi-pen prescribed: Yes No

*An *Allergy Action Plan* form will need to be completed by the Doctor 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 _____ *A *Diabetic Medical Management Plan* will need to be completed by the Doctor to ensure a safe school environment for your child.

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

If yes, describe type and medications taken: _____

*A *Seizure Action Care* Form will need to be completed by the Doctor to ensure a safe school environment for your child

* All Asthma/Allergy/Diabetes/Seizure care plan forms can be obtained from the School Nurse or downloaded from the school web site.

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:

YES **NO CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: _____ Date: _____

Thank you for completing this form