STUDENT HEALTH HISTORY UPDATE

Student Name: _____ **DOB:** _____ **Grade:** _____

Student Health History Update: This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

1. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

☐ ADD/ADHD	☐ Blood Disorder	☐ Bowel/Bladder	☐ Hearing	☐ Kidney	☐ Speech
☐ Allergies	☐ Body Piercing/Tattoo	☐ Diabetes	☐ Heart	☐ Physical Disability	☐ Surgery
☐ Asthma	☐ Bone/Spine	☐ Emotional	☐ Infections	☐ Seizures	☐ Vision

☐ Other: _____

Comments: _____

2. Does your child have allergies to medicine, food, latex or insect bites? ☐ Yes ☐ No

To What? _____ What Happens? _____

Treatment: _____

3. Has your child had any illnesses since school last ended? ☐ Yes ☐ No

What type of illness, with date(s): _____

4. Has your child had surgery since school last ended? ☐ Yes ☐ No

Type of surgery, with date(s): _____

5. Has your child received any immunizations since school last ended? ☐ Yes ☐ No

List immunization, with date(s): _____

6. Is your child being treated or evaluated for any health conditions? ☐ Yes ☐ No

List condition(s): _____

7. Is your child on any medication or treatment? ☐ Yes ☐ No

Name of medication and/ or treatment: _____

Does your child need medication during school hours? ***If yes, please contact the school nurse to make arrangements***. ☐ Yes ☐ No

8. Has your child every been examined by an eye doctor? ☐ Yes ☐ No

Date of last exam: _____ If your child wears glasses or contact lenses, when was the prescription last changed? _____

9. What is the name of your child's dentist? _____ Phone #: _____

What is the date of his/her last dental exam: _____

10. What is the name of your child's primary healthcare provider? _____ Phone#: _____

What is the date of his/her last physical exam? _____

11. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year? ***If yes, please contact the school nurse or school counselor*** ☐ Yes ☐ No

12. Have you, your child or anyone in your household tested positive for COVID-19? ***If yes, please contact the school nurse*** ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____

Student Name: _____

Additional Health/Medical Information: This information will be shared with staff and administration on a need to know basis, and with emergency medical staff in the case of an emergency, unless you notify us otherwise.

1. Does your child have a food allergy documented by a licensed healthcare provider? ☐ Yes ☐ No

To What? _____ What Happens? _____

Treatment: _____

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy.

2. Will your child require an individualized, allergen-free menu designed by a Red Clay Registered Dietitian?

Note: Meals provided from home provide the safest food options at school for food-allergic students.

☐ **No.** I will take full responsibility of providing my child with allergen-free school meals.

☐ **Yes.** I will provide the school nurse with a Food Allergy Action Plan completed by a licensed healthcare provider. Failure to provide physician documentation will result in your student receiving a standard allergy meal.

Medical Information					
Medical Insurance:				Type:	
Certificate No:		Group No:		Medicaid No:	

I give permission for my child to have the following; as determined by the nurse:

Acetaminophen (Tylenol®) ☐ Yes ☐ No Ibuprofen (Advil®) ☐ Yes ☐ No Tums® ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date**: _____

School Emergency Procedures: Your schools have adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician until one is reached.
7. The information on this form may be shared with emergency medical staff.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

By signing this form I acknowledge understanding and attest to the accuracy of the information.

Parent/Guardian Signature: _____ **Date:** _____