STUDENT HEALTH HISTORY FORM AND RELEASE OF INFORMATION ~ SCHOOL YEAR 20___ **Student ID**_____
(official use only)

Student Name (*print first*) _____ **(*print last*)** _____ **DOB** _____ **Grade** ___ **F** ☐ **M** ☐

Your student's health history is important to provide the best care at school. It is the responsibility of the parent /guardian to notify the school of new or existing health concerns. If your student is prescribed medication or requires a treatment at school, it is the responsibility of the parent or guardian to notify the school and provide the medication or necessary equipment for use at school.

Last physical exam _____ Healthcare Provider _____
Last dental exam _____ Dental Provider _____
Last vision exam _____ Vision Specialist _____

My student has the following (NEW or EXISTING) medical condition(s). (Check all that apply)

HEAD
- ☐ Concussion (loss of consciousness)
- ☐ Concussion (no loss of consciousness)
- ☐ Migraines (diagnosed)
- ☐ Frequent headaches
- ☐ Seizures
- ☐ Other _____ _____

EYES
- ☐ Vision concerns
- ☐ Glasses/Contacts
- ☐ Vision Loss/both eyes
- ☐ Vision Loss/one eye
- ☐ Other _____ _____

EAR/NOSE/THROAT/ MOUTH
- ☐ Frequent earaches/infections
- ☐ Tubes in place
- ☐ Hearing loss/condition
- ☐ Hearing aid
- ☐ Speech problems
- ☐ Swallowing problem
- ☐ Dental pain or concerns
- ☐ Other _____ _____

HEART/LUNGS
- ☐ Asthma
- ☐ Heart condition
- ☐ Other _____ _____

ABDOMEN/INTESTINAL/ URINARY
- ☐ Frequent stomachaches
- ☐ Urinary or bowel concerns
- ☐ Other _____ _____

BONE/MUSCLE/JOINT
- ☐ Muscular concerns
- ☐ Knee, back, bone or joint concerns
- ☐ Scoliosis
- ☐ Other _____ _____

CHROMOSOME/GENETIC
- ☐ Down Syndrome
- ☐ Other _____

SKIN
- ☐ Skin concerns
- ☐ Other _____

ALLERGIES
- ☐ Anaphylactic shock
- ☐ Anaphylactic/foods
- ☐ Anaphylactic/nuts
- ☐ Anaphylactic/peanuts
- ☐ Anaphylactic/stings
- ☐ Allergy, Airborne
- ☐ Allergy, Animals
- ☐ Allergy, Medication
- ☐ Allergy, Food
- ☐ Allergy, Latex
- ☐ Lactose Intolerance

List specific allergy(ies):
_____
_____
_____

ENDOCRINE/BLOOD
- ☐ Diabetes/Type I
- ☐ Diabetes/Type II
- ☐ Blood disorder
- ☐ Other _____ _____

EMOTIONAL/BEHAVIORAL /PSYCHOLOGICAL
- ☐ Mental/emotional concerns
- ☐ Other _____ _____

OTHER
- ☐ _____
- ☐ _____

☐ **My Child has NO (new or existing) health concerns.**
(If you check this box, you agree to communicate with the school regarding new health concerns during the school year.)

My child will require the following medication types given during the school day (check all that apply):

☐ **Long-Term Prescribed Medication**
The Long-Term form must be completed by the parent/guardian AND healthcare provider: MD/DO/ANP/PA & medication delivered in a properly labeled pharmacy container.

☐ **Short-Term Prescribed Medication**
The Short-Term form must be completed by parent/guardian & medication delivered in a properly labeled pharmacy container.

☐ **OTC/Over the Counter Medication**
To have an Over-The-Counter medication at school, a parent must complete a separate form and provide medication in the original container.

My child will require the following emergency medication(s) at school, check all that apply (*parent/guardian must provide*):
- ☐ Epinephrine (EpiPen or Auvi-Q)
- ☐ Antihistamine (Benadryl)
- ☐ Rescue Inhaler
- ☐ Glucagon
- ☐ Diazepam rectal gel

My child will require the following plan or other treatment at school (check all that apply):
- ☐ Student Allergy/Anaphylaxis Action Plan
- ☐ Asthma Action Plan
- ☐ Individualized Healthcare Plan -Diabetes with injection
- ☐ Individualized Healthcare Plan –Diabetes with pump
- ☐ Seizure Action Plan
- ☐ Other treatment in school

***Release of Information: The disclosure of health information within the school is limited to information necessary to serve the student's health and education interests. Your *voluntary* agreement gives permission for school staff to be informed of precautions and procedures necessary to protect your child at school and foster academic success.**

☐ I Agree _____ ☐ I Disagree _____ **Parent/Guardian Signature** _____ **Date** _____

Form adapted from Anchorage School District Nursing & Health Services 7-2013