Student Health History

Name________________________________ Date of Birth_____________________ Male ☐ Female ☐

Please check any health concerns that apply:

ALLERGIES

Student has allergies ☐
☐ Bee/insect sting: Describe Reaction
☐ Medication Allergy ____
Describe Reaction ____
☐ Food Allergy ____
Describe Reaction ____
☐ Environmental Allergy ____
Describe Reaction____

ASTHMA
WHAT TRIGGERS
ASTHMA ATTACKS

Student has Asthma ☐
☐ Smoke ☐ Exercise ☐ Illness ☐ Allergies
Other ____
List asthma medication ____

ATTENTION DEFICIT
DISORDER (ADD/ADHD)

Student has ADHD or ADD ☐
Treatment ____

EMOTIONAL/BEHAVIORAL
CONCERNS

Student has emotional concerns ☐
Diagnosis ____
Treatment ____

DIABETES

Student has diabetes ☐
☐ Insulin Dependent
☐ Non-Insulin Dependent

EATING/DIGESTION
DISORDER

Student has eating or digestive disorder ☐
Details ____

KIDNEY/BLADDER
DISORDER

Student has a kidney or bladder disorder ☐
Details ____

HEART DISORDER

Student has a heart disorder ☐
Details ____

MUSCLE/JOINT/BONE
DISORDER

Student has a disorder with muscles, joints, or bones ☐
Details ____

VISION

Student has a vision concern ☐
Details ____
☐ Contacts ☐ Glasses ☐ Vision Loss ☐ Color Blindness
Other – Please specify: ____
Date of last exam __________________

HEARING

Student has a hearing disorder ☐
☐ Ear Infections ☐ Tubes in ears ☐ Hearing Aides ☐ Speech Therapy
☐ Hearing Loss
Details ____

HEADACHES/MIGRAINES

Student has significant headaches or migraines ☐
Frequency ____
Treatment ____

HEAD INJURY

Student had a previous head injury ☐
Date ____________________
Severity ____

SEIZURES

Student has seizures ☐
Type ____
Frequency ____
Medication ____

PAST SURGERIES

This student has had previous surgeries ☐
Details ____

PAST MAJOR ILLNESS/INJURY

Student had MAJOR past injuries or illnesses ☐
Details ____

MEDICATIONS

Student regularly takes medications ☐
Student takes medications at home ☐
Please list: ____
Student takes medications at school ☐
Please list: ____

If you suspect your child's health condition is a disability that could substantially limit their learning or another major life activity, you may request a meeting with the school to evaluate if additional services or accommodations are needed. Please contact the school nurse to request this evaluation.

OTHER MEDICAL CONDITIONS OR LIMITING PHYSICAL DISORDERS

Does this student have other limiting conditions or physical disorders? ☐
Details: ____
____
____
____

Were there any concerns with the child's health and/or development during pregnancy, delivery or infancy? If so, please explain. ______________________________
____
____
____

Physician Name ________________________________ Phone ______________________

Medications

My student may take

Acetaminophen/Tylenol (All grades)	☐ Yes / ☐ No
Ibuprofen/Advil (6th-12th gr. ONLY)	☐ Yes / ☐ No

Certification and Medical Consent

As the Legal Guardian of this student, I certify that the above information is accurate as of today's date and consent to the treatment of our minor child by a medical physician or medical personnel at any hospital OR temporary treatment by a registered or licensed practical nurse or emergency medical technician until a medical physician can be obtained for any illness or injury to our minor child while on or adjacent to any school grounds of the West Ada School District. This consent shall include, but not be limited to, any surgery deemed required or desirable for immediate health and medical treatment of our child. This consent shall be effective only if none of the undersigned can be contacted or found by reasonable diligence at the time of the needed medical treatment. This consent shall terminate as soon as any of the undersigned are contacted, in which case further medical treatment can be done only with the consent of the person contacted. This consent shall be valid unless and until revoked in writing by one of the undersigned.

Today's Date ______________
Parent/Guardian Name ____
Parent/Guardian Signature ____