

GENEVA AREA CITY SCHOOLS
Health History 2019--2020

Student (Print) _____ Date of Birth _____ Grade _____

Please (X) any of the following conditions your child has experienced:

___Hearing Problems (Circle) Yes/No When? _____ Tubes (Circle) Yes/No When? _____

___Visions problem (Circle) Yes/No Problem _____ Wears glasses/Contacts (Circle) _____

___Diagnosed ADD or ADHD-Since when? _____ Medication _____

Will medication be needed in school? Yes/No (Circle) When? _____

___Allergies-List _____

What happens? _____

Is Epi-pen prescribed for allergies? Yes/No. If yes, parents must provide Epi-pen.

___Bee Sting Allergy-What happened? _____

Is Epi-pen prescribed? Yes/No. If yes, parents must provide Epi-pen.

___Asthma-Is an inhaler used? Yes/No. How often? _____

List medications for asthma _____

Doctor and Phone _____ Date last seen _____

___History of Chicken Pox? Yes/No Date _____ Vaccine Date _____

___Diabetes-When was it diagnosed? _____ Glucose testing needed _____

Medication taken _____ Doctor and Phone _____

___Seizures-What Type? _____ Last seizure _____

Medication taken _____ Doctor and Phone _____

___Hospitalizations-For what? _____

___Episode of loss of consciousness? Yes/No (Circle) When? _____

___Bone/joint problems or fractures? Yes/No (Circle). Is a brace worn? _____

What bone or joint and when? _____

___Emotional Concerns-List _____

___Depression-How long? _____ Medications? _____

___My child is healthy and has no health problems.

Has your child seen a doctor for anything in the past year besides a physical exam? Yes/No

What for? _____

Please list any other recurrent medical problems or unusual illness you would like the nurse to be aware of: _____

Please contact the school nurse for medication forms if your child needs medication at school, including inhalers for asthma or Epi-pens for severe allergies. Your child may carry an inhaler if medically authorized and developmentally appropriate, after informing the nurse. Students will receive periodic grade level vision and hearing screening and screening for scoliosis.

Health History Informed Consent

The disclosure of student health information within the school is limited to the information necessary to serve the student's health and education interest. Your signature gives permissions for the nurse to inform school staff of precautions and procedures to protect your child in the classroom and to foster academic success.

Your signature is an informed consent to share this health history with the school staff on a need-to-know basis for academic success and emergency plans, as determined by the nurse.

X _____
Parent/Guardian Signature Phone Number Date