

# Student Health Services

20\_\_ - 20\_\_

The school health service is concerned with helping parents provide the best care possible for their children. Help us achieve this goal by furnishing the following information for your children's health record.

Student's Name: \_\_\_\_\_

Date of Birth \_\_\_ - \_\_\_ - \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Grade \_\_\_\_\_

## PLEASE INDICATE IF YOUR CHILD HAS OR EVER HAD THE FOLLOWING, IF SO, PLEASE EXPLAIN.

1. Emotional problems? \_\_\_\_\_
2. Learning Disability? \_\_\_\_\_
3. Attention Deficit Disorder/Hyperactivity \_\_\_\_\_  
Medication used? \_\_\_\_\_ When and where given? \_\_\_\_\_ How often? \_\_\_\_\_
4. Speech problems (indicate specific problem, e.g., stuttering, lisp, etc.) \_\_\_\_\_  
If yes, is your child being treated? Explain where, by whom and what time? \_\_\_\_\_
5. Hearing Impaired? If yes, does your child have a hearing aide, ear tubes, receive medication, etc.? \_\_\_\_\_
6. Visually Impaired? If yes, does your child wear glasses, contacts, have sty's, etc.? \_\_\_\_\_

## PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOUR CHLD HAS OR HAS HAD:

(If yes, please explain in detail, send medical information and see the office for additional forms.)

- |   |                                     |                 |
|---|-------------------------------------|-----------------|
| 1. Allergies (drugs, food, environment) | 7. Rheumatic Fever                  | 13. Fainting    |
| 2. Asthma                               | 8. Tuberculosis                     | 14. Convulsions |
| 3. Diabetes                             | 9. Sickle Cell Anemia               | 15. Other _____ |
| 4. Bone Disorders                       | 10. Significant weight loss or gain |                 |
| 5. Heart or Cardiac Disease             | 11. Seizures                        |                 |
| 6. Kidney Disease                       | 12. Frequent dizziness              |                 |

Explanations: \_\_\_\_\_

## SPECIFIC SYMPTOMS WE SHOULD KNOW ABOUT such as minor complaints:

Please explain, in detail, what procedures to take should they occur during school hours.

- |                          |                   |                |
|--------------------------|-------------------|----------------|
| 1. Frequent Headaches    | 4. Hives          | 7. Migraines   |
| 2. Sore Throats          | 5. Nosebleeds     | 8. Other _____ |
| 3. Frequent Stomachaches | 6. Frequent colds |                |

Explanations: \_\_\_\_\_

## MEDICAL INFORMATION

Please answer all the following questions:

Doctor's name \_\_\_\_\_ Office # \_\_\_\_\_ Emergency # \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Group Policy # \_\_\_\_\_

Hospital preference (EMS or other consideration will override parent preference) \_\_\_\_\_

Any limits of Physical Activity (If yes, send paperwork) \_\_\_\_\_ Why \_\_\_\_\_

Is student under physician's care \_\_\_\_\_ For what condition? \_\_\_\_\_

Medication taken or as needed (name, dosage, & frequency) \_\_\_\_\_

I have made the school aware of all pre-existing and current health problems, illnesses, diseases and/or injuries my child has had or has at the present.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_