STREATOR ELEMENTARY SCHOOLS STUDENT HEALTH HISTORY 2018-2019

In order to better serve your child at school, please complete the following:

Student's Name: ____ Birthdate: ____________________ Sex: M ◻ F ◻

Home Address: ____ School/Grade/Teacher: _______________/_____/__________

Phone Home: ___________________________ Cell: ___________________________ Work: ___________________________

Physician/Health Care Provider: _______________________________ Address: _______________________________________

Phone Office: ____ Fax: ____

Has your child ever had or currently has any of the following (Use back if needed):

	NO	YES	COMMENTS/EXPLAIN
ADD/ADHD			
Allergies			List allergies: ____ (If your child has a food allergy, an *Allergy History Form* needs to be completed). Has your child been allergy tested? NO ◻ YES ◻ Date tested: ______________ Is an EpiPen needed at school? NO ◻ YES ◻ (If yes, a *Medication Authorization Form* needs to be completed and you must bring the EpiPen to the school's office).
Asthma			List asthma triggers: ____ Is an Inhaler needed at school? NO ◻ YES ◻ (If yes, a *Medication Authorization Form* needs to be completed and you must bring an inhaler to the school's office).
Birth Defects			
Blood Disorders			
Bone/Joint Problems			
Diabetes			Age diagnosed: __________ (If yes, please plan to meet with appropriate school personnel to plan your child's Diabetes Care Plan).
Ear/Hearing Problems			Hearing Aids: Right ear ◻ Left ear ◻ Both ears ◻ Date of last exam: _______________
Eye/Vision Problems			Glasses: NO ◻ YES ◻ Constant Wear ◻ Reading ◻ Date of last exam: _______________
Headaches/Head Injury			Please inform the school if your child experiences a concussion as it could affect learning.
Heart/Lung Problems			
Lead Poisoning			Age: ________ Treated: NO ◻ YES ◻ Current Lead Level (if known): _______
Mental Health Problems			
Seizures			Describe: ____ Age diagnosed: ________ Date of last seizure: _______________ Is medication needed at school to control seizures? NO ◻ YES ◻ (If yes, a *Medication Authorization Form* needs to be completed and you must bring the medication to the school's office).
Skin conditions/Rashes			
Stomachaches/Bowel Problems			
Serious Injury			When? What?
Hospitalization/Surgery			When? Why?
Other Health Concerns			

Please list ALL medications your child takes regularly:

Medication Dosage Purpose Times given (If medication needs to be given at school, a *Medication Authorization Form* needs to be completed and you will need to bring the medication to the school's office.)
School: NO ◻ YES ◻ Time to be given:
School: NO ◻ YES ◻ Time to be given:
School: NO ◻ YES ◻ Time to be given:

Consent of Parent or Guardian:

I agree to the mutual exchange of health information between my child's school and his/her health care provider(s).

___________________________________ ___________________________________ ____________________

Printed Parent/Guardian Name Parent/Guardian Signature Date