WAYLAND-COHOCTON CSD

2350 ROUTE 63, WAYLAND, NY 14572

STUDENT HEALTH HISTORY FORM, RELEASE OF HEALTH INFORMATION ETC. _____ (YEAR)

Student Name (print) First: _____ 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 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 Physician Exam: _____
Last Dental Exam: _____
Last Vision Exam: _____

Healthcare Provider: _____
Dental Provider: _____
Vision Specialist: _____

HEAD

- ☐ Concussion (loss of consciousness)
- ☐ Concussion (No loss of consciousness)
- ☐ Migraines (diagnosed)
- ☐ Frequent headaches
- ☐ Other: _____ _____

EYES

- ☐ Vision concerns
- ☐ Glasses/contacts
- ☐ Vision loss/2 eyes
- ☐ Vision loss/1 eye
- ☐ Other: _____ _____

EAR/NOSE/THROAT/MOUTH

- ☐ Frequent Earaches/infections
- ☐ Tubes in place
- ☐ Hearing loss/conditions
- ☐ Hearing aid
- ☐ Speech problems
- ☐ Dental pain or concerns
- ☐ Other: _____ _____

HEART/LUNGS

- ☐ Asthma
- ☐ Heart Conditions
- ☐ Other: _____ _____

ABDOMEN/INTESTINAL/ URINARY

- ☐ Frequent stomach aches
- ☐ Urinary or Bowel
- ☐ 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, latex
- ☐ Lactose intolerance

List specific Allergies: _____ _____ _____ _____

ENDOCRINE/BLOOD

- ☐ Diabetes/Type1
- ☐ Diabetes/Type2
- ☐ 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.)

CURRENT MEDICATIONS	
Given at School (Dr's Order Needed:	YES NO
Taken at Home:	YES NO
Please list names, dose, time(s): _____ _____ _____	

CONTINUED ON THE BACK

My child will require the following emergency medication(s) at school. Check all that apply (parent/guardian must provide medication:

- ☐ Epinephrine (EpiPen or Auvi-Q)
- ☐ Antihistamine (Benadryl)
- ☐ Rescue inhaler
- ☐ Glucagon
- ☐ Diazepam

My child will require the following plan or other treatments 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: _____

Are there any conditions that would prevent your child from participating in physical education? YES NO (Explain)

_____

_____

Please list any additional concerns (use another sheet if necessary): _____

_____

COVID-19 Information

Has your child ever tested positive for COVID-19? YES NO
If NO, stop and go to LIVING SITUATION, If YES, please check appropriate boxes below:
Date of Positive COVID Test: _____
Was your child symptomastic? YES NO
Did your child see a health care provider for their COVID-19 symptoms? YES NO
Was your child hospitalized with COVID? YES NO
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)? YES NO

LIVING SITUATION

Is there a current Order of Protection or No Contact Order which concerns this student? YES NO
Please attach a copy of any legal paperwork concerning this child.

Complete this section only if it reflects your child's current living situation: Or your living situation if you are a youth not living with a parent or guardian. (Your answer will help school staff with school enrollment and may enable the student to receive additional services.) Check one box if you are living:

- ☐ In a shelter
- ☐ In an abandoned apartment or building
- ☐ With relatives or others due to a lack of housing
- ☐ At a train or bus station due to lack of housing
- ☐ At a train or bus station, park or in a car
- ☐ In a motel/hotel, camping ground, or other similar situation due to lack of alternative, adequate housing
- ☐ Temporarily housed in a shelter awaiting DCFS permanent foster care placement

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Release of Health Information: The information on this form is confidential. The disclosure of health information with 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. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school

I Agree I Disagree Parent/Guardian Signature:_____ Date: _____

I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstances.

I Agree I Disagree Parent/Guardian Signature:_____ Date: _____

Print name of Parent/Guardian Signature:_____ Date: _____