Decatur Memorial Hospital

# HEALTH HISTORY

***Dear Parent/Guardian**: Please complete the information below for your child's health record. This information is strictly confidential and allows the nursing staff to ensure the health safety of your child. If an emergency does arise and your child needs to be sent to the hospital, a copy of this form may accompany them. It is important that the information is complete and up-to-date. Thank you for filling out this form. Please return the completed form to the school nurse.*

Student's Name: _____ Grade/Teacher: _____ Birth Date: _____

| *Please indicate if your child has had or now has any of the following:* | YES | NO |
|---|---|---|
| Chicken Pox | ☐ | ☐ |
| TB Explosure | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| name of inhaler: _____ | | |
| Blood Disorder | ☐ | ☐ |
| Serious Injury | ☐ | ☐ |
| describe: _____ | | |
| Birth Defect | ☐ | ☐ |
| describe: _____ | | |
| Allergies | ☐ | ☐ |
| food: _____ medications: _____ bee sting: _____ | | |
| History of head injury | ☐ | ☐ |
| Eye/Vision Defect | ☐ | ☐ |
| Ear/Hearing Defect | ☐ | ☐ |
| Heart Defect | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Bone/Joint Disorder | ☐ | ☐ |
| Developmental Delay | ☐ | ☐ |
| Hospitalization | ☐ | ☐ |
| describe: _____ | | |
| Surgery | ☐ | ☐ |
| describe: _____ | | |
| Medications | ☐ | ☐ |
| list current medications and dosage: _____ | | |

*From the "yes" answers above, please describe in detail:* _____

_____

List other health concerns not listed above: _____

_____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Hospital Preference: _____

I, _____ , give permission for the school nurse to treat my child if/when an emergency arises and to provide the necessary information to school personnel and emergency personnel.

_____

Parent/Guardian Signature Phone Number Date

FORM 15-245