ECHS@DSU

dream BIG dreams

Health History Update – 2018/2019

Student's Name: _____ Date: _____

`DOB: _____ Entering Grade: _____

1. Please check if your child has had difficulty with any of the following since last school year. Give dates and additional information under comments.

(_) ADD/ADHD	(_) Body Piercing/Tattoo	(_) Emotional	(_) Physical Disability
(_) Allergies	(_) Bone Problem	(_) Hearing	(_) Seizures
(_) Asthma	(_) Bowel/Bladder	(_) Heart	(_) Speech
(_) Behavior	(_) Chicken Pox	(_) Infections	(_) Surgery
(_) Bleeding	(_) Diabetes	(_) Kidney	(_) Vision

(_) Other: _____

Comments: _____

_____

2. Does your child have allergies to medicine, food, latex or insect bites?

(_) No (_) Yes To What?_____ What happens?_____

Treatment? _____

3. Does your child have any chronic illnesses that we need to be aware of? _____

_____

4. Has your child had any illnesses since school ended in May?

(_) No (_) Yes Type of illness with date(s):_____

5. Has your child had surgery since school ended in May?

(_) No (_) Yes Type of surgery, with date(s): _____

6. Has your child received immunizations since school ended in May? (Provide updated Vaccination History)

(_) No (_) Yes List immunizations, with date(s):_____

See Other SIde

7. Is your child being treated or evaluated for any health conditions?

( ) No ( ) Yes List Conditions:_____

8. Is your child on any medication or treatment?

( ) No ( ) Yes Name of Medication/Treatment: _____

Does your child need to take medication during school hours?

( ) No ( ) Yes * ***If yes, please contact the school nurse for further instruction***

9. Does your child carry an asthma quick relief inhaler?

( ) No ( ) Yes **** If yes, please complete an Asthma Care Plan and the permission to administer medication and permission to carry inhaler forms***.

10. Does your child carry an EPIPEN?

( ) No ( ) Yes **** If yes, please complete an Emergency Care Plan and the permission to administer medication and permission to carry EPIPEN form***s.

11. Has your child been examined by an eye doctor?

( ) No ( ) Yes Date of last exam:_____ Glasses prescribed: ( ) No ( ) Yes

If your child wears contacts, when was the last time the prescription was changed? _____

12. Has your child had any emotional upsets (recent move, death, separation, divorce, etc.) since school ended in May?

( ) No ( ) Yes List: _____

13. What is the name of your child's dentist? _____

What is the date of his/her last exam? _____

14. What is the name of your child's physician? _____

When was his/her last physical? _____

_____ _____

Parent/Guardian Signature Date

Thank you for your time!