# Tussey Mountain School District
## HEALTH HISTORY UPDATE

School year ____ - ____

Name of Student:_____ Date of Birth: _____

☐ No ☐ Yes **Glasses/Contacts**, Date of last eye exam: _____

☐ No ☐ Yes **Hearing limitation**, Date of last hearing exam: _____

**Primary Doctor:** _____ **Date of last physical exam:**_____

**Dentist:** _____ **Date of last dental visit:** _____

**Medications**

State law requires written permission from a Health Care Provider **and** guardian before any medication can be given at school. The only over-the-counter medications that will be given without specific doctor orders are those approved by the school doctor- Please refer to the district's medication policy and the attached medication permission form.

☐ No ☐ Yes **Will need routine medication at school** *if yes- see nurse- additional form will need completed*

☐ No ☐ Yes **Medication taken at home** (List medicine name, dose, frequency and reason for use):

_____

_____

**Medical Conditions-**

**The school nurse should have this information and any necessary medications prior to your child starting school. Medication, Allergy or Asthma Forms for your doctor to complete are available from the school nurse or the TMSD website. The nurse may contact you for further details if warranted.**

| | | |
|---|---|---|
| **ADD/ADHD** | ☐ No<br>☐ Yes | ☐ On Routine Medication ☐ Diagnosis: _____<br>ADD/ADHD Doctor's name _____ |
| **Allergy** | ☐ No<br>☐ Yes | ☐ Environmental/Seasonal ☐ Takes medication at home<br>☐ Bee Sting/Insect Bite Allergy ☐ Mild-Moderate ☐ Severe (life threatening)<br>☐ Food Allergy: _____<br>☐ Medication Allergy to: _____<br>☐Emergency medication (Epi-pen) needed ☐ Benadryl needed<br>Allergy Doctor's Name_____ |
| **Asthma** | ☐ No<br>☐ Yes | ☐ Routine medication ☐ Rescue Inhaler/Nebulizer<br>Asthma Doctor's Name _____<br>Type of Asthma _____ |
| **Cardiac (Heart)** | ☐ No<br>☐ Yes | ☐ Takes medication ☐ Diagnosis: _____<br>Heart Doctor's Name _____ |
| **Diabetes** | ☐ No<br>☐ Yes | ☐ Type 1 ☐ Type 2 ☐ Needs blood sugar checks ☐ Oral medications<br>☐ Insulin- INJECTIONS or PUMP (circle) ☐ Has Glucagon<br>Diabetes Doctor's Name/Phone Number _____ |
| **Epilepsy (Seizures)** | ☐ No<br>☐ Yes | ☐ Routine Medication ☐ Diastat ☐ Other treatment: _____<br>Date of last seizure: __/__/____ Doctor's Name_____ |
| **Physical Limitations** | ☐ No<br>☐ Yes | Type _____ ☐Assistive Device<br>Doctor's Name _____ ☐ Gym Restriction |
| **Feeding/Diet Consideration** | ☐ No<br>☐ Yes | ☐ Difficulty Swallowing ☐ Feeding Tube (Type_____)<br>**Dietary Restrictions** (MD note required for cafeteria staff to give substitutions)<br>_____ |
| **Other** | **Describe:** _____<br>_____ | |

*All health information is considered and kept confidential. It may be shared with staff as needed in order to ensure the health and safety of your child, unless otherwise requested by you in writing.*

**Parent/guardian signature** _____ **Date** _____

** PLEASE update the **school nurse** of any new or changed medical conditions occurring during school year **