Ridgefield School District
Student Health History
To be completed by parent/guardian

Student Name: _____ Date of Birth: _____Grade: ___ □ Male □ Female

Parent Name: _____Phone #: _____Teacher: _____Bus#___

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

*If your child has a life-threatening condition, state law requires a medication and/or treatment orders from a Licensed Health Professional and an Emergency plan must be in place **before your child can attend school**. See office for forms. Please check appropriate boxes below and explain if needed*

Health Condition	Yes	No	Explanation if "Yes" checked
Food Allergies	O	O	**Food(S): O peanut O tree nut O dairy O eggs O other_____ Rate the reaction: O mild O moderate O life-threatening Does your child require an EpiPen? O yes O no Is this allergy a food sensitivity? O yes O no Please describe symptoms:**
Allergy to Bee Stings	O	O	**Rate the reaction: O mild O moderate O life-threatening Describe the reaction: _____ Does your child require an EpiPen? O yes O no**
Medication Allergies	O	O	**List:**
Allergies (other)	O	O	**List:**
Asthma	O	O	**Rate the severity: O mild Omoderate O life-threatening Asthma medication taken at home: _____ Medication required at school: _____ Last asthma attack:_____**
Diabetes	O	O	**O Type 1 (insulin Dependent) O Type 2 Diabetes medications(s) taken at home:**
Seizure Disorder	O	O	**Type of seizure: Medications:**
Heart Condition	O	O	**Specify:**
Cancer	O	O	**Specify:**
Blood Disorder	O	O	**Specify: Treatment:**
ADD/ADHD	O	O	**Medication for ADD/ADHD:**
Mental Health / Behavioral Issues	O	O	**Specify: Treatment/Medication:**
Orthopedic Condition	O	O	**Specify:**
Wears glasses	O	O	**O For Distance O For Reading**
Hearing Loss	O	O	**Hearing Loss O Right Ear O Left Ear O Hearing Aids**
Headaches/migraines Head Injury	O	O	**Please Describe:**
Other:	**Describe:**		

Does your child have any other condition that would affect his/her classroom performance or P.E. activities? × No × Yes if so, please explain: _____

Daily Medication

State law requires written permission from a Licensed Health Professional and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

× No × Yes Medication needed at school- specify: _____

× No × Yes Medication needed at home- specify: _____

This information is considered confidential. It will be shared with school staff and emergency responders as needed during the time your child is enrolled in Ridgefield School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

** *As the Parent/Guardian you are responsible for communicating any changes in your child's health condition with the school nurse. This form will be put in your child's permanent health file and will continue year to year unless you notify the school nurse of changes regarding your child's health condition. ***

Parent/guardian signature: _____Date:_____