STUDENT HEALTH HISTORY

Name: _____Grade:_____Age: _____ Birthdate: _____

Parent/Guardian_____

Address: _____ Best Number: _____

Home Number _____ Cell Phone _____ Work Phone: _____

Medicaid/ARKids number _____

Who do we contact in an emergency if parent/guardian unavailable:

#1_____ Contact Number_____

#2_____ Contact Number_____

#3_____ Contact Number_____

Student's Doctor_____ Doctor's Phone #_____

<u>History</u>

Does this child have a history of any of the following health concerns:

- ❑ **Diabetes _____** ❑ **Asthma/Lung problem _____**
- ❑ **Seizures _____** ❑**High Blood Pressure_____**
- ❑ **Heart Disease_____** ❑ **Cystic Fibrosis _____**
- ❑ **Irregular Heart Beat_____** ❑ **Fainting Spells _____**
- ❑ **Stomach/Bowel problem _____** ❑ **Cancer_____**
- ❑ **Bladder/Kidney problems _____** ❑ **Sickle Cell Disease/Trait _____**
- ❑ **Heat exhaustion _____** ❑ **Organ Transplant _____**
- ❑ **Musculoskeletal (include any past fractures, etc.) _____**

Does this child have any allergies? ❑ Yes ❑ No

If "yes", please list: _____

Has the allergy required emergency treatment? ❑ Yes ❑ No

If "yes", please explain: _____

Has this allergy been verified by a medical professional? ❑ Yes ❑ No

If "yes", please attach documentation of proof.

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No

If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ Yes ❑ No

If "yes", please list: _____

Does this child take any medication regularly at home? ❑ Yes ❑ No

Require medication at school? ❑ Yes ❑ No

If "yes", please list: _____

Please list any additional concerns or information: _____

_____

Who lives with the child in his/her primary household? _____

Does child spend a significant amount of time in another household? ❑ **Yes** ❑ **No**

If "yes", please describe: _____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

Is your child experiencing:

Eating Problems ❑ **Yes** ❑ **No**
Sleeping Problems ❑ **Yes** ❑ **No**
Vision Problems ❑ **Yes** ❑ **No**
Hearing Problems ❑ **Yes** ❑ **No**

Does your child wear glasses or contacts? ❑ **Yes** ❑ **No**

When was he/she last seen by the eye doctor? _____

Is there anything the school needs to know about your child that will help in providing health services? If so please list:

_____

_____

SCHOOL EMERGENCY MEDICAL AUTHORIZATION

If the above named student becomes seriously ill or injured at school and the family cannot be reached immediately for instructions, I hereby authorize school personnel to call and/or arrange for transportation of the student to the nearest facility for emergency care

It is understood that I am responsible for the cost incurred for emergency transportation and care unless otherwise covered by insurance.

Note: Parents/Guardians are responsible for notifying the school about any change of information contained on this form.

Signature_____ **Date:** _____

(Parent or Guardian)