AVONWORTH SCHOOL DISTRICT – STUDENT HEALTH HISTORY

(To be completed by parent/guardian)

Student's Name_____ Sex____ Date of Birth_____

I. *<u>LIFE THREATENING ALLERGIC CONDITIONS</u>***: (Check all that apply)**

<u>**Be sure to complete an Allergy Action Plan!!!!!**</u> **You can get this from the school nurse.**

___Severe allergic reaction to Bee Stings, other insects: _____

___Severe reaction to Nuts, Peanuts: _____

___Severe reaction to other Food Products: _____

___Other severe allergies affecting student: _____

Has an EpiPen been prescribed? (EpiPen must be provided to the school) YES NO

List symptoms of allergies:_____

_____

Please note: Information on life threatening conditions may be shared with staff for safety purposes*

II. <u>SPECIAL HEALTH NEEDS</u>: CIRCLE "YES" or "NO". Provide dates and details for all "YES" answers

YES **NO** Has the student ever had any serious illness or operations? What/When? _____

_____

YES **NO** Is the student currently seeing a doctor or taking daily medication? For what? _____

_____

YES **NO** Does the student need to take any medication at school? What and why? _____

_____

YES **NO** Does the child have any allergies to medications, foods or things in the environment? __

_____

YES **NO** Does the student have a special diet? Please provide details: _____

_____

YES **NO** Does the student have any other special health needs or problems that the nurse should be aware of? Please explain: _____

_____

III. <u>DEVELOPMENTAL HEALTH HISTORY</u>: CIRCLE "YES" or "NO". Provide details for all circled "YES"

YES **NO** Did the mother have any difficulties during the pregnancy? _____

YES **NO** Did the baby come on time?

_____ What was the baby's birth weight?

YES **NO** Did the baby have any trouble while in the hospital?_____

YES **NO** Did the baby have any trouble in the first six months?_____

_____ At what age did the child walk alone?

_____ At what age did the child say two words together?

YES **NO** Is the child completely toilet trained?

IV. HEALTH HISTORY: CHECK "YES" or "NO". Provide details for any "YES" answers.			
YES	**NO**	**CONDITION**	**Details/Dates**
		Attention Deficit: ____ADD or ____ADHD Date diagnosed:_____ Meds: YES / NO	
		Asthma/Reactive Airway ****If YES - Fill out Asthma Action Plan**** -You can get this from the school nurse Uses an inhaler? YES / NO Med: _____ Uses a nebulizer? YES / NO Dose: _____	
		Autism/PDD	
		Arthritis / Rheumatic disease	
		Behavioral Problem	
		Bleeding disorder	
		Bowel or digestive problem	
		Cancer, Type:_____ Date diagnosed_____	
		Cerebral Palsy	
		Chromosomal disorder: Down's Syndrome_____ Other (specify)_____	
		Cleft lip/palate	
		Cystic Fibrosis	
		Dental problems	
		Diabetes: Date diagnosed:_____ Insulin dependent: YES / NO	
		Eating disorder: specify →	
		Emotional problem: specify →	
		Growth problems	
		Heart problem: specify →	
		Hernia	
		High blood pressure	
		Hospitalizations: specify →	
		Immunodeficiency disease	
		Kidney or urinary problem	
		Lyme disease	
		Muscular disorder	
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone/joint)	
		Scoliosis/abnormal spinal curve: Date of diagnosis:_____ Date of last evaluation:_____	
		Seizure disorder, Type _____ Date of last seizure: _____ Meds: YES / NO Medication_____ (Please provide physician documentation of diagnosis)	

YES	NO	CONDITIONS	Details/Dates
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Tics or twitches	
		Other	

YES	NO	
		My child is healthy and has no special health needs

V. HEARING

YES **NO** Has your child ever had any hearing loss?

If YES please provide details

Hearing loss:

[ ] Right - ___Mild ___Moderate ___Severe

[ ] Left - ___Mild ___Moderate ___Severe

Hearing loss due to:_____

Last evaluation:_____

Hearing aid: [ ] Right [ ] Left [ ] Bilateral

VI. VISION

YES **NO** Color deficiency?

YES **NO** Legally blind?

YES **NO** Vision problem/Eye defect: _____ Last eye exam:_____

YES **NO** Wears glasses [ ] All the time [ ] For distance only [ ] For reading only [ ] Other

YES **NO** Wears contact lenses

*****If your child has a medical condition that requires medication in school, a written physician's order is required. No medication may be carried in school by a student; this includes "over-the-counter" medications. All medication must be delivered to the School Health Office by the parent/guardian with the physician's original order and written parental permission. See attached or you can get the necessary paper work from the Health Office.*****

I understand and agree that if my child's health status changes during the school year, I will provide the Health Office with updated information.

Parent/Guardian Signature_____ Date _____