FORM 5
(All Students)

Health History

Student Name: _____ **Teacher:** _____
Grade: _____ **Birth date:** _____

Yes	No	Health Information
☐	☐	**Attention Deficit Disorder (ADD/ADHD)** Medication:
☐	☐	**Allergies** (If YES, mark below and explain) ☐ Food ☐ Insect bites/stings ☐ Pollens ☐ Animals ☐ Medication Explain: Will your child use an Epi-Pen at school? ☐ Yes ☐ No
☐	☐	**Asthma** Medication: Will your child have an inhaler at school? ☐ Yes ☐ No
☐	☐	**Bone/Muscle Condition** Explain:
☐	☐	**Diabetes** Medication:
☐	☐	**Ear or Throat Infections, Chronic** Explain:
☐	☐	**Emotional Problems** Medication &/or Counseling:
☐	☐	**Fainting** Has the student ever experienced a sudden loss of consciousness? ☐ Yes ☐ No If so, please explain:
☐	☐	**Frequent Headaches or Migraines** Treatment:
☐	☐	**Head Injuries or Major Accidents of any kind** Explain:
☐	☐	**Heart, Blood Disease or High Blood Pressure** Explain:
☐	☐	**Hearing Loss** Degree of Impairment: Hearing Aid: ☐ Yes ☐ No
☐	☐	**Physical Handicap** Explain:
☐	☐	**Seizure Disorder** Type of seizure: Medication:
☐	☐	**Skin Problems** Explain:
☐	☐	**Urinary/Bowel Condition** Explain:
☐	☐	**Vision Problems** (If YES, please mark below) ☐ Glasses ☐ Contact lenses ☐ Wears all the time ☐ Wears some of the time ☐ Eye Surgery, (explain):
☐	☐	**Other Health Concerns Including Hospitalizations or Operations Not Previously Mentioned:**
☐	☐	**Is there anything at this time you would like to discuss with the school nurse?**

If more room is needed to explain the above health information, please use the back of this form.

For the safety and well being of your child, this medical information will be released to school personnel working with your child. A signed student information sheet is on file with emergency contact information. In case of serious accident or illness at school, your child will be sent to an emergency medical facility. The parent(s)/guardian(s) is responsible for all expenses.

All medications given at school (over-the-counter OR prescriptions) must have a signed consent form from the doctor AND parent on file before medication will be given at school.

Signature: _____ Date: _____

12/04