STRIDE ACADEMY

ANNUAL HEALTH HISTORY 2019-2020

The school requests a new annual health history be completed and returned each school year. Information provided will be shared with pertinent staff members only to ensure students' safety at school.

Student Name: _____ Birth Date: _____Grade: _____

___ NO - Medical Conditions or Medical Concerns

___ YES - The following Medical Conditions Or Medical Concerns:

Life-Threatening Conditions:

☐ **Asthma:** Does your child use a rescue inhaler more than once a week? **Circle: Yes No**
Has your child been hospitalized for asthma symptoms in the past year? **Circle: Yes No**
Has your child used steroids for asthma symptoms in the past year? **Circle: Yes No**

☐ **Severe Allergy:** Allergen(s)_____
Has your child required use of an Epi-Pen in the past? **Circle: Yes No**

☐ **Diabetes:** Diagnosis date:_____ ☐ Type 1 OR ☐ Type 2 CGM: ☐ Yes ☐ No ☐ Pump OR ☐ Injections
☐ Manages Independently OR ☐ Needs Assistance

☐ **Seizures:** Type:_____ How Often:_____
Does your child's seizures require daily medication? ☐ No ☐ Yes: _____
Does your child require emergency seizure medication? ☐ No ☐ Yes: _____

Other Medical Conditions Or Medical Concerns that could affect your child at school?

Please list below. (**Examples**: Medication, **Food Intolerance**, or Seasonal Allergies, ADHD, Anxiety, Encopresis, Heart Conditions, Migraines, Crohn's, Diet Concerns, Eczema, Genetic, History of Concussions, Cerebral Palsy, Depression, PKU, Enuresis, Blood Disorders, etc.)

_____

_____

Wears Glasses/Contacts: ☐ Glasses OR ☐ Contacts ☐ At all Times ☐ For Reading Only
Hearing Loss: ☐ Hearing Loss Right Ear ☐ Hearing Loss Left Ear ☐ Hearing Aid(s)

2. Medications Required At School:

Medication Name	Dose and Time	Diagnosis or Symptom requiring medication

- **All medications** require a signed consent from the parent/guardian.
  - ***Prescription medications:*** require a copy of the provider's order and must come in a pharmacy labeled container. Provider orders and label must match.
  - ***Over the counter medications:*** must come in their original container. Medications can only be given as directed on the bottle. *New Consents & Orders required each year.*

The information on this form may be shared confidentiality with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstances.

(Office Use Only)
Office Review:
_____

⇨ _____ _____

(Printed Name **and** Signature of Parent/Guardian Completing Form) (Today's Date)