



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)

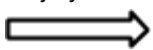
2. Medications Required At School:

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)