# Diller-Odell Schools Health History Form
# School Year________ Grade______

Student Name_________________________ Birth Date____________ Male__ Female__
Parent/Guardian Name(s) ____________________________________________________
Student lives with: Mom Dad Step-Mom Step-Dad Foster Parent(s) Siblings
Other___________________________________________________________________

The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's safety and educational success. Please contact the school nurse if you have questions. Return the completed form to the school health office. Thank you!

____________________________________ ____________________
Parent/Guardian Signature Date

If you would rather not share this information please sign below***. It is highly recommended this form be completed to the best of your ability to ensure adequate care is given to your child during school hours.***
I do not wish to complete this form. __________________________________ ______
Parent/Guardian Signature Date

A. **Current Health Status**
   1. Does your child have any allergies? Yes No
      If yes, please list and include reaction type:

   2. Does your child take medicine or supplements regularly? Yes No
      If yes, please list all meds:

      Will any of these be taken at school? Yes No
      If so, which medications will be given at school? *(The school requires a Medication Authorization Form signed by a parent/guardian and a physician is on file in order to administer the medication.)*

   3. Does your child have a health condition now under treatment?
      Yes No

If yes, please explain:

4. Do you have any concerns about your child's health? Yes No
   If yes, please explain:

5. Date of last medical exam________________________ Dr.________________

6. Date of last dental exam_________________________ Dr._________________

7. Date of last vision exam__________________________Dr._________________

8. Is there personal finance or insurance barriers making routine healthcare difficult to obtain for this student? Yes No

9. If yes, would you be interested in health resources from the school nurse? Yes No

B. **Conditions**

Please circle any condition your child may currently have or has had in the past.

| | | |
|---|---|---|
| Asthma | Chickenpox | Hives |
| Pneumonia | Diabetes | Seizures |
| Rheumatic Fever | Heart Problems | Kidney Problems |
| Nosebleeds | Hay Fever | Head Injury |
| Broken Bones | Tonsillitis | Sleep Apnea |
| Ear Infections | Eating Problem | Coordination Problem |
| Tires Easily | Bowel Problem | Frequent Headaches |
| Migraines | Weight Problem | Eczema |
| Anger Control | High Blood Pressure | Blood Disorder |
| Concussion | Color Blindness | Emotional Concerns |
| Behavior Concerns | Hearing Problem | Vision Problem |
| Meningitis | RSV | MRSA |
| Staph Infection | History of Abuse | Born Prematurely |
| Hospitalizations | Surgeries | |

Please explain: ___________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
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C. **Primary Care Physicians**

Family Doctor ______________________________ Phone ____________________

Eye Doctor ________________________________ Phone ____________________

Dentist ____________________________________ Phone ____________________