Health History Form

Student Health Department

School Year: 20____/ 20_____

Student:	Date of Birth:	Grade:
School:	Homeroom Teacher:	

Parent/Guardian/Emergency Information	Relationship	Best Phone #
1.		
2.		
Name of Healthcare Provider:		
Is this the first time the student has attended KippNC in North Carolina? Yes _____ No _____		

Indicate if a doctor has diagnosed the student with any of the following medical conditions:

For medication or procedure required during the school day, please see the school nurse for forms.

Health Condition	Yes	No	Explanation, if "Yes"	
ADHD/ADD			Medication at home:	Medication needed at school? Yes*____No____
Allergies to food, list:			Rate the reaction: Mild___Moderate____Life-threatening___ Does your child require an Epi-Pen? Yes*____No____ Special diet at school*, describe:	Allergy specialist, if applicable:
Allergies to stings			Rate the reaction: Mild____Moderate_____Life-threatening____	Does your child require an Epi-Pen? Yes*___No__
Allergies (severe) other:			Specify:	Does your child require an Epi-Pen? Yes*___No__
Asthma			Rate the severity: Mild____Moderate_____Life-threatening_____ Rate frequency of symptoms: Often _____Rarely _____ Medication at home:	Does child have Inhaler? _____Nebulizer? _____ Date inhaler/nebulizer last used_____ Medication required at school? Yes*____No ___
Autism or Asperger's				
Blood Disorder			Specify:	Treatment:
Bone/Muscle Issues			Specify:	Activity restrictions: Yes* _____No_____
Bowel/Bladder Issues			Specify:	Treatment:
Cancer			Specify:	Treatment:
Concussion/Head Injury			Complications:	Date of injury:
Diabetes			Type I (Insulin-dependent): ____ Pump____ Pen_____ Type 2 ____ Medication at home:	Doctor: Medication required at school? Yes*____No ___
Emotional/Behavioral Psychiatric Disorder			Specify: Medication at home:	Doctor: Medication required at school? Yes*____No ___
Genetic Condition			Specify:	
Hearing Issues/Loss			Right ear: _____ Left ear: _____	Hearing aid(s)/devices: Yes_____ No_____
Heart Issues			Specify:	Activity restrictions? Yes* _____No_____
High Blood Pressure			Medication:	Low blood pressure: Yes _____ No _____
Migraine Headaches			Triggers:	Medication:
Seizures			Type: Medication at home:	Date of last seizure: Medication at school*:
Health Condition	Yes	NO	Explanation if yes	

Sickle Cell Disease			**Medication:**	**Trait only: _____**
Skin Issues			**Type:**	
Stomach Issues			**Specify:**	**Medication/Treatment:**
Surgeries			**Specify:**	**Dates:**
Thyroid/Endocrine Issues			**Specify:**	**Medication:**
Vision Issues			**Wears glasses/contacts: Yes _____No_____**	**Vision doctor:**
Other Illness, Injury, or condition not listed			**Specify:**	
Procedure* / Assistive Device needed at school			**Specify:**	

Form required – contact School Nurse

Yes___ No ___

The school nurse has my permission to contact my child's healthcare provider about health conditions checked above.

Parent/Guardian Signature: _____ **Date:** _____

This information will be kept confidential and shared only to ensure student's health, safety, and well-being at school. It is the responsibility of the parent/guardian to notify the school about health conditions and if emergency contacts/phone numbers change, complete emergency and/or individualized health plans, provide the medication, written healthcare provider's orders, and equipment supplies needed at school.

Reviewed by School Nurse_____

Date_____

Forms sent _____