

CCSD Health Services ANNUAL STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|--|--|---|
| <input type="checkbox"/> ADHD
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Dental Injuries
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Condition
(depression, eating disorder, anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Urinary Condition |
|--|--|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Please list any additional concerns: (use back of sheet if necessary) _____

OVER-----

HEALTH CARE PROVIDERS:

Local Physician: _____

Local Dentist: _____

REQUIRED PHYSICALS: Education law requires every child have a physical examination in Pre-K, Kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grades and annually for sports participation. If you prefer to have your child examined by your family physician, please send a copy of the report to school within 30 days of the start of school. If a report of the physical exam is not received, we will schedule your child for a physical to be done by the school physician.

PARENT AUTHORIZATION:

I prefer to have my child examined by: (please choose one):

My family physician _____

The school physician _____

In case of serious accident or illness, I authorize the above named physician or dentist to treat my child in my absence.

Signature of Person Completing Form

Relationship

Date

Printed Name

Reviewed By Nurse _____
Signature/Title

Date

3/5/18mnf