### University School Health History Form

**Part 1: Parent/Guardian to complete.**
The parent/guardian is encouraged to participate in the development of an Individual Healthcare Plan.

**Student's Name:** Last  
First  
Preferred  
Sex  
DOB  

<table>
<thead>
<tr>
<th>Grade</th>
<th>Parent/Guardian's Name</th>
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<tr>
<th>Home Phone</th>
<th>Mother's Cell</th>
<th>Father's Cell</th>
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My child has a medical condition that may affect his/her school day  
☐ No  
☐ Yes (please complete part 2)

**Parent/Guardian’s Name (print)**  
**E-mail address**  

**Parent/Guardian's Signature**  
**Date**

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**Part 2: Complete all boxes that apply to your child.** Parent/guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Check with the school office to obtain correct medication forms. If an IHP is indicated, the parent/guardian is responsible for providing the school nurse with the necessary medical information and forms. Please see link to locate your child’s school nurse and forms [www.etsu.edu/coe/uschool/faculty/nurse/default.aspx](http://www.etsu.edu/coe/uschool/faculty/nurse/default.aspx)

#### ALLERGIES

- **Allergy Type**
  - ☐ Food  List food(s)  
  - ☐ Bee/Insect Sting  
  - ☐ Medication  List Medication(s)  
  - ☐ Other  List  

Describe your child’s allergic reaction symptoms:

**Date of last severe reaction?**

Does your child require a classroom designation (peanut, nut, dairy, or seafood “free”, etc.)?  
☐ Yes  
☐ No  

Does your child need to sit at a specific allergy free area in the cafeteria?  
☐ Yes  
☐ No  

Will your child be staying in the after school program at school?  
☐ Yes  
☐ No

**Currently Prescribed medications and treatments**

- ☐ Oral antihistamines (Benadryl, etc.)  
- ☐ Epi-Pen  
- ☐ Other  

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#### ASTHMA

- **Triggers**
  - ☐ Exercise  ☐ Environmental  ☐ Other  

**Currently Prescribed Medication and treatment**

- ☐ Inhalers  
- ☐ Oral antihistamines

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April 2014
University School

Health History Form

☐ Oral steroid Nebulizer
☐ Oral Bronchodilator
☐ Peak Flow Monitoring

Will your child require medication at school?  ☐ No  ☐ Yes

Has student been hospitalized for asthma? Date of last hospitalization?

☐ DIABETES

Currently Prescribed Medications and treatments
(A Medication Authorization Form is required for all medications at school.)

☐ Insulin via  ☐ Syringe  ☐ Pen  ☐ Pump
☐ Blood sugar testing
☐ Carbohydrate Counting
☐ Glucagon
☐ Oral Medication(s)  List Medication(s) ____________________________

Date of last hospitalization related to diabetes ____________________________

Contact School Nurse to discuss Diabetes Care Plan [includes Diabetes Medical Management Plan (DMMP) and Individualized Healthcare Plan (IHP)]

☐ SEIZURE DISORDER

Type of seizure
☐ ____________________________

Date of last seizure ____________________________ Length of last seizure ____________________________

Physical Education Restrictions  ☐ No  ☐ Yes ____________________________

Currently prescribed medication(s) ____________________________

Medications needed IN SCHOOL  ☐ No  ☐ Yes ____________________________

(A Medication Authorization Form is required for all medications at school.)

☐ OTHER HEALTH CONDITIONS

Special Procedures (catheterization, cardiac monitor, etc.) required IN SCHOOL  ☐ No  ☐ Yes

Explain ____________________________

☐ MEDICATION(S) NEEDED IN SCHOOL  ☐ No  ☐ Yes

List Medication(s) ____________________________

☐ PHYSICAL RESTRICTIONS

Does your child’s health condition restrict participation in Physical Education?  ☐ No  ☐ Yes

If yes, please explain restrictions ____________________________

RETURN COMPLETED FORM TO SCHOOL OFFICE

April 2014