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

Grade	Parent//Guardian's Name

Home Phone	Mother's Cell	Father's Cell

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 _____

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

□ **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 _____

□ **ASTHMA**

Triggers

□ Exercise □ Environmental □ Other _____

Currently Prescribed Medication and treatment

□ Inhalers
□ Oral antihistamines

- □ 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