CENTENNIAL SCHOOL DISTRICT

SCHOOL HEALTH SERVICES HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN)

The information provided is confidential. This information is necessary for the health and safety of the student to assist in promoting optimal healthcare to facilitate the academic success of each student. Thank you for your time.

NAME OF CHILD: _____
Last First Middle

ADDRESS: _____
Street City State Zip

HOME PHONE NUMBER: _____ E-Mail address_____

DATE OF BIRTH: _____ Grade _____ MALE:_____ FEMALE:_____

FATHER'S (GUARDIAN) NAME: _____ CELL #:_____
Last First

MOTHER'S (GUARDIAN) NAME: _____ _____ CELL #:_____
Last First

CHILD'S PHYSICIAN: _____ PHONE NUMBER:_____ DATE OF LAST EXAM:_____

CHILD'S DENTIST: _____ PHONE NUMBER:_____ DATE OF LAST EXAM:_____

LAST SCHOOL ATTENDED: _____

ADDRESS: _____PHONE NUMBER:_____

DISEASE/DISORDER HISTORY OR ILLNESS
Please check any of the following that apply:

	Yes	No		Yes	No
Allergies/Environmental			**Eating Disorder**		
Allergies/Food			**Endocrine Disorder**		
Allergies/Insect Stings or Bees			**Head or Spinal Injury**		
Allergies/Latex			**Headaches/Migraines**		
Allergies/Medications			**Hearing Problem**		
Allergies/Other			**Heart Defect or Disease**		
Asthma/Breathing Disorder			**Hepatitis or Liver Problem**		
Behavioral Disorder			**Hypertension**		
Bladder/Kidney Disorder			**Immune System Disorder**		
Bleeding/Clotting Disorder			**Mobility Limitation**		
Bone/Joint/Muscular Disorder			**Psychological/Emotional Problem**		
Cancer			**Scoliosis**		
Convulsions/Epilepsy/Seizure			**Skin Condition**		
Developmental Disorder			**Urinary/Bladder/Kidney Disorder**		
Dizziness or Fainting			**Speech Disorder**		
Diabetes			**Surgery or Hospitalization**		
Dietary Restriction			**Vision or Eye Disorder**		
Digestive/Bowel Disorder			**Other (explain below)**		

- Was a medical evaluation performed for any condition/disorder checked 'yes': Yes_____ No_____

Please turn page over and complete the other side

DISEASE/DISORDER HISTORY OR ILLNESS (con't)

My child is under a Doctor's care for Asthma: Yes □ No □ If yes, medications taken:_____
*An *Asthma Action Plan* form will need to be completed by the Doctor to ensure a safe school environment for your child.

My child is under a Doctor's care for a Severe Allergy to _____
Please describe the allergic reaction: _____

Epi-pen prescribed: Yes ☐ No ☐
*An *Allergy Action Plan* form will need to be completed by the Doctor to ensure a safe school environment for your child.

My child is under a Doctor's care for Diabetes: Check type: Type 1_____ Type 2 _____ *A *Diabetic Medical Management Plan* will need to be completed by the Doctor to ensure a safe school environment for your child.

My child is under a Doctor's care for Seizures: Yes ☐ No ☐
If yes, describe type and medications taken: _____
*A *Seizure Action Care* Form will need to be completed by the Doctor to ensure a safe school environment for your child

* All Asthma/Allergy/Diabetes/Seizure care plan forms can be obtained from the School Nurse or downloaded from the school web site.

MEDICATION HISTORY
Does your child take medication on a daily basis (include homeopathic and nutritional supplements)? Yes □ No □

Please list all medications taken and what the medication or supplement is for:
_____
_____

SOCIAL HISTORY
Have there been any changes in your family during the past year, such as:
Separation, divorce, or remarriage? Yes □ No □
Death or serious illness? Yes □ No □
Any other situation, which may affect your son/daughter? Yes □ No □
If yes, please explain:_____
_____

MISCELLANEOUS
Please list any condition and/or restrictions that your child may have which might limit his/her activities in school. Please include any comments that you think might be helpful:
_____
_____
_____

☐ YES ☐ **NO** **CONSENT TO SHARE INFORMATION**: The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: _____ Date: _____

Thank you for completing this form