HEALTH HISTORY FORM
2020-2021

Students Name: _____ Grade: _____ Birthdate: _____

Address: _____

MOTHER'S Name: _____ DOES CHILD LIVE WITH: Yes_____ No_____

Work Number: _____ Cell Number: _____

FATHER'S Name: _____ DOES CHILD LIVE WITH: Yes_____ No_____

Work Number: _____ Cell Number: _____

EMERGENCY CONTACTS (OTHER THAN PARENTS):

Name: _____ Phone Number: _____ Relation: _____

Name: _____ Phone Number: _____ Relation: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Dentist's Name: _____ Dentist's Phone Number: _____

Health Insurance: _____ Dental Insurance: _____ Vision Insurance:_____

HAS YOUR CHILD RECEIVED ANY IMMUNIZATIONS SINCE LAST SCHOOL YEAR? Yes_____ No_____
(*If YES, please send documentation to update their file*)

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING NOW?

YES	NO	DESCRIPTION
		*FOOD ALLERGY? (if yes, list foods, reaction, and treatment)
		*BEE STING ALLERGY? (if yes, what reaction and treatment)
		SEASONAL/ENVIRONMENTAL ALLERGY? (if yes, list allergies)
		*ASTHMA? (if yes, list medications used) **Controlled/Mild Moderate Severe (Please circle one) *WILL INHALER BE USED AT SCHOOL? YES NO**
		ADD/ADHD? (if yes, list medications used)
		DIABETES? (if yes, Type 1 or Type 2)
		SEIZURES? Date of last known seizure:
		HEART CONDITION? (if yes, list medications or condition)
		MENTAL HEALTH CONDITION? (if yes, list conditions)
		DOCTOR ORDERED SPECIAL DIET? (if yes, list diet ordered)

If EpiPen is prescribed for allergy we WILL need an Allergy Action Plan

If inhaler will be used at school or asthma is Moderate or Severe, we WILL need a current Asthma Action Plan

PLEASE COMPLETE BACK SIDE OF FORM →

MEDICATION:

YES	NO	DESCRIPTION
		IS YOUR CHILD TAKING ROUTINE MEDICATIONS AT THIS TIME?
		WILL PRESCRIBED MEDICATIONS BE REQUIRED DURING SCHOOL HOURS PER DOCTORS ORDER?

If yes to either, please list medication and reason taken: _____

STATE LAW INDICATES NO MEDICATIONS ARE TO BE GIVEN THE FIRST OR LAST HOUR OF SCHOOL; SPECIAL CIRCUMSTANCES WILL HAVE TO HAVE PRIOR APPROVAL. LISTED BELOW ARE SOME OF THE TEMPORARY MEDICATIONS AVAILABLE AT THE SCHOOL IF A MINOR ILLNESS OCCURS. THEY MAY BE ADMINISTERED BY THE NURSE OR A TRAINED STAFF MEMBER. THE MEDICATIONS MAY BE GENERIC OR NAME BRAND AND DOSAGE WILL BE DETERMINED BY THE MANUFACTURER'S LABEL. PLEASE MARK YES OR NO FOR EACH MEDICATION LISTED:

YES	NO	MEDICATION/USE
		Tylenol-mild pain, fever, headache
		Benadryl-allergy symptoms, itchy or runny nose, sneezing, hives, insect bites, rash, etc.
		Tums-indigestion, sour stomach, gas
		Ibuprofen-minor aches and pains, toothache, fever
		Cough Drops-minor throat irritation/cough (if requested more than 2 days in a row, parent will be contacted)
		Sore Throat Spray-minor throat irritation
		Anbesol or Orajel-tooth or gum pain
		Calamine or Anti-Itch Lotion-minor skin irritations, itching

BY SIGNING BELOW, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THE SCHOOL HEALTH PROGRAM (INDLUDING SCREENINGS AND MEDICATION ADMINISTRATION). I ALSO GIVE PERMISSION FOR THE MACON COUNTY HEALTH DEPARTMENT AND THE SCHOOL TO EXCHANGE INFORMATION REGARDING MY CHILD'S IMMUNIZATION RECORD. MY SIGNATURE ALLOWS MY CHILD'S HEALTH CONCERNS TO BE SHARED WITH APPROPRIATE STAFF ON A NEED TO KNOW BASIS ONLY.

PARENT/GUARDIAN SIGNATURE_____DATE_____

IN THE EVENT THAT MY CHILD IS INJURED OR BECOMES ILL AND/OR NEEDS MEDICAL ATTENTION FOR ANY REASON, AND I CANNOT BE CONTACTED, THIS AUTHORIZATION WILL SERVE AS MY REQUEST AND AUTHORITY FOR SCHOOL AUTHORITIES TO CALL AN AMBULANCE SERVICE FOR THE PURPOSE OF CONVEYING MY CHILD TO THE HOSPITAL, AND I AUTHORIZE ANY AND ALL MEDICAL TREATMENT PROVIDED TO MY CHILD. I HEREBY AUTHORIZE THE SCHOOL TO PROVIDE TO THE ATTENDING PHYSICIAN, HOSPITAL, OR CLINIC, RELEVANT DATA FROM MY CHILD'S FILE DEEMED NECESSARY FOR TREATMENT. I FULLY UNDERSTAND THAT I SHALL BE RESPONSIBLE FOR ALL COSTS OF AMBULANCE SERVICE, AND ANY MEDICAL CARE OR TREATMENT PROVIDED TO MY CHILD. I ALSO GIVE PERMISSION FOR THE SHARING OF HEALTH INFORMATION WITH APPROPRIATE STAFF MEMBERS AND MEDICAL PERSONNEL WHEN NECESSARY FOR THE WELLBEING OF MY CHILD.

IN THE EVENT OF AN ANAPHYLACTIC EMERGENCY, I AUTHORIZE TRAINED SCHOOL PERSONNEL TO ADMINISTER PRE-FILLED EPINEPHRINE (EPI-PEN) AND/OR BENADRYL. I ALSO AUTHORIZE TRAINED SCHOOL PERSONNEL TO ADMINISTER FIRST-AID TO MY CHILD.

PARENT/GUARDIAN SIGNATURE_____DATE_____