Building________________

STUDENT HEALTH HISTORY

(To be completed by parent/guardian)

USD 465 WINFIELD, KANSAS, SCHOOL DISTRICT

Student Name: ________________________________ **Date of Birth** ____-____-_____ **Grade** ______

(Last, First, Middle Initial)

I understand if my child's health status changes during the school year, I will provide the Nurse's Office with updated information.

YES	NO	Has a physician diagnosed your child with a chronic medical condition? Please provide physician documentation of diagnosis when possible.
		List medical problem(s), details, dates, and medications required:
		Asthma Does your student use an inhaler? Yes_____ No_____
		Diabetes
		Seizures Does your student take anti-seizure medication? Yes_____ No_____
		Will your child be taking medications at school? If so, please list medications below:
		Severe reaction to nuts, peanuts
		Severe reaction to other food products, please list below:
		My child uses an Epi-Pen
		Severe reaction to bee stings, other insects
		Other severe allergies affecting schools such as environmental allergies, please list below:
		Vision Problems (specify)
		Hearing Problems (specify)
		Emotional Concerns (Depression, Anxiety, Mood Disorder, ADHD), please list below:
		Other Concerns, please list below:

Student's Primary Care Provider__________________________________ **Office Phone**__________________

Student's Dentist____ **Office Phone**__________________

This information may be shared with school staff as needed. If a parent or authorized person cannot be reached, I authorize school officials, in the event my child is injured or in need of medical attention, to take emergency action at parent's expense. I give my consent for information contained on the Kansas Certificate of Immunizations to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

Parent/Guardian Signature______________________________ **Date** _________________________