Health History Assessment

		Yes	No
1	Have you ever had a serious medical problem requiring surgery, hospitalization or prolonged treatment by a doctor? If yes, please explain: _____		
2	Have you ever had a serious allergic reaction to anything? (**please list below)** Food_____ Insects_____ Medication_____ Epi-Pen Required_____		
3	Have you ever had seasonal allergy problems?		
4	Do you have any form of asthma that requires medication or inhalers?		
5	Do you have the sickle cell trait?		
6	Do you have a heart murmur, irregular heart beat or at any other cardiac concern? If yes, please explain? _____		
7	Have you ever been dizzy or passed out during exercise or at any other time?		
8	Has any family member ever had a heart attack or died suddenly before age 50?		
9	Do you ever have chest pain or tire more easily than others while exercising, or any other time?		
10	Have you ever suffered any heat related problems such as heat cramps, heat exhaustion or heat stroke?		
11	Have you ever had a significant injury such as a sprain, fracture or dislocation to a bone or joint? If yes, please explain? _____		
12	Have you ever had a concussion or been knocked unconscious? If yes, when and how many times? _____		
13	Have you ever had a seizure? If yes, please explain? _____		
14	Is there any other medical or family history that might be important? If yes, please explain? _____		
15	Have you ever been taken out of or kept from participating in a sports activity or practice for an injury or physical reason? If yes, please explain? _____		
16	Do you have damage or absence of one of any paired organs (i.e. kidney, testicle, eye, etc)? If yes, please explain? _____		
17	Do you have any skin problems? If yes, list _____		
18	In the last year how much weight have you gained or lost? _____		
19	**FEMALES ONLY** In the last year have you gone for three months or more without a period?		

Medication Authorization

Does your student currently take any prescription or non-prescription medication on a regular basis? ☐ Yes ☐ No

If yes, please list all medications: _____

_____

Does your student require any medication to be given during school hours on a daily basis? ☐ Yes ☐ No

OTC MEDICATION DISTRIBUTION AT SCHOOL

OTC MEDICATIONS MAY be given by the School Nurse at her discretion when the student requests. All medications will be given as directed by the manufacturer and ONLY WITH PARENT CONSENT:

☐ Acetaminophen ☐ Ibuprofen ☐ Benadryl ☐ Midol ☐ Antacid Tablets ☐ Nasal Decongestant ☐ Cold Relief

PARENT:

I give permission for my child to receive medication or treatment in school:

PARENT SIGNATURE: _____ **DATE:** _____