**TO BE COMPLETED BY PARENT**

This form must be completed, signed by parent or guardian, and returned to the school nurse prior to entering school. Date entering school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_/\_\_\_\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_\_ Weight \_\_\_\_\_\_\_ Date of last Tetanus Shot \_\_\_/\_\_/\_\_\_\_\_\_\_

Medication/food allergies (and reaction) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy to bee stings? ( ) yes ( ) no If Yes (reaction) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Epi-Pen? ( ) yes ( ) no

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Is there a history of: (Indicate **YES** or **NO** and write comments or explanations in the section indicated below for **ALL YES** answers. Use back if needed.)

YES NO YES NO

Allergies/Hay Fever O O Elevated Blood Pressure O O

Asthma O O Headaches O O

Inhaler? O O Head Injury/Concussion O O

Anemia O O Heart Problem/Murmur-Chest pain O O Arthritis O O Nose Bleeds/Frequent or Severe O

Bladder/Kidney Problem O O Ankle Injury O O

Convulsions/Seizures O O Back Pain/Injury O O

Fainting Spells O O Fracture-Dislocation Bones/Joints O O

Diabetes O O Knee Pain/Injury O O

Ear Problems/Hearing Loss O O Neck Injury O O

Eye Problems/Vision Loss O O Nose Fracture O O

Injury to the Spleen O O Rheumatic Fever O O

Joint Sprain/Ligament Tear/ O O Stomach Ulcer O O

Muscle Pull

Comments on all YES answers above or any other health problems/concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses? \_\_\_\_\_ Yes \_\_\_\_ No Contacts? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of last eye exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what was the reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on any medications? \_\_\_\_\_Yes \_\_\_\_\_No If yes list all medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your child need to take any medication(s) while at school? \_\_\_\_\_\*Yes \_\_\_\_\_No If yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Reminder:** Medication Administration Form must be completed and on file in health office before your child will be allowed to take any medications while at school (Self-Medication&Attestation forms are also required for student to carry and self-administer their medications: such as their inhaler or Epi-Pen)

Date of last physical examination (will need to have copy on file in health office) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had screening or evaluation by any other health professionals (such as speech therapist, neurologist, psychiatrist, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this student require any special attention due to physical limitations? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student's physician/primary care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_