For School Nurse Use Only
Needs HCP: Yes / No
HCP created/updated: ______________
☐ School Staff Notified
☐ Entered on Permanent Health Record
☐ Entered on Daily Log

Cleveland County Health Department
School Health Services

School ___________________

Health History

The following is a brief health history form. This information is essential for the school to be properly prepared to take care of any special health needs your child/student may have during the school day. Please be assured that this information will be guarded with confidentiality as specified by the Family Rights and Privacy Act.

Please complete this form in ink and return it to your child's school to be reviewed by the School Nurse.

Student Name	Birthdate	Teacher	Grade

Address (Number, Street, City, State, Zip)	Phone Number

Parent / Guardian(s)	Work Phone	Cell Phone

Does your child ride the bus to or from school? Please check one: ________ Yes ________ No Bus # __________

Student's Health Insurance is: (Please check one)
☐Medicaid ☐Private Insurance/HMO ☐No Insurance ☐Other: ____________

☐ Please check if you would like information about Insurance coverage for children

Physician Name and Address	Physician's Phone No.

Dentist Name and Address	Dentist's Phone No.

<u>If you indicate below that your child/student has a health condition, please be aware that it is the practice of the School Nurse to develop/update health care plans yearly to assist school staff in caring for students with known health conditions.</u> Please do not return this form without first contacting the School Nurse if you object to the development of a health care plan. This plan will be reviewed by school staff caring for the student and added to his/her permanent school health record. The School Nurse is available to discuss with any questions you have. *In addition, please note that School Nurses document health services using a cloud based electronic health record and that all records are protected and confidential as required by law.*

<u>PLEASE CHECK BELOW (with ink) IF CHILD/STUDENT HAS EVER HAD ANY OF THE FOLLOWING:</u>

- ☐ Allergies: What kind and reaction? ___________________________
- ☐ ADD/ADHD
- ☐ Asthma: Known triggers ___________________________________
- ☐ Blood Disorder (including sickle cell)
- ☐ Blood Pressure Problem
- ☐ Cancer: Type: ____
- ☐ Diabetes
- ☐ Growth or Developmental Problems
- ☐ Orthopedic Problems: Explain: ____________________________
- ☐ Headaches / Migraines: Known triggers: ____________________
- ☐ **Head Injury/Concussion diagnosis in the past year**
  Please explain: ____
- ☐ Hearing Problems
- ☐ Heart Problems: Restrictions: Yes___ No___
- ☐ Infectious Disease
- ☐ Kidney Problems
- ☐ Seizure Disorder: Type of seizure: _________________________
- ☐ Vision Problems (glasses / surgery)
- ☐ Special Diet: Explain: ___________________________________
- ☐ Other: ____

Date of last Tetanus (Td/Tdap) Shot: _______________________

Does student take any medication on a daily basis? Yes _____ No _____

Please list the name, dosage, and time medication is taken:

____
____
____
____
____

***Please NOTE that a health care provider's order will be needed for any medication needed during the school day.**

***Kindly notify the School Nurse of any change in health status.**

Has student ever had a serious illness, accident, or been hospitalized? Yes _____ No _____
If yes, please explain: ____
Please explain any of the above: ____

Will student need to take any medication at school? Yes _____ No _____ If so, please review **Parent Information Regarding Medication in School** and complete the ***<u>Request for Medication to Be Given During School Hours</u> Form.*** You may obtain this information and medication form from the school.

Parent / Guardian Signature: ____ Date: _______________

Revised 7/2021