MELIORA making life better

Student Health History

Name (Last, First, Middle)	Check: ☐Female ☐Male	Date of Birth: ____/____/______ MM DD YYYY

Medical History

Check all that apply and explain below or attach additional page(s).

COVID-19 VACCINATION INFORMATION

Covid-19 Vaccination? ☐Yes ☐ No (**If yes, provide copy of vaccination card.**)

Booster? ☐ Yes ☐ No

Do you give the nurse permission to test for COVID-19 at school if he/she has symptoms?

☐ Yes ☐ No (Parents will be notified of the results immediately)

Signature____ **Date:**__________________

Vision	Respiratory	Asthma	Allergies	Hearing
☐Wears glasses for reading ☐Wears glasses full time ☐Wears contact lens ☐Color deficiency ☐other_______________	☐Bronchitis ☐Cystic Fibrosis ☐Sinusitis ☐Other ________________	Date of Diagnosis: ___________ Inhaler needed @ school Y N @ home Y N	☐Bee sting ☐Drugs ☐Environmental ☐Food: (Special diet/ avoid) ☐Lactose Intolerance ☐Seasonal ☐Anaphylaxis ☐Other	☐Frequent ear infections ☐Ear Tubes Y N Insertion date:_____________ Are tubes currently in place? Right Y N Left Y N

Cardiovascular	Psychiatry	Special Health Care Procedures	Endocrine
☐Sickle Cell Disorder ☐Heart Murmur ☐Hemophila ☐Other bleeding disorder: _____________________ ☐Rheumatoid heart disease ☐Other: ______________________	☐Anorexia ☐Bulimia ☐Autism ☐ADD/ ADHD ☐Depression ☐Anxiety ☐Mood Disorder ☐Other: ______________	☐My child will/ may require special health care procedures during the school day. (See page 2) ☐Ileostomy / Colostomy ☐Catheterization ☐G-tube Feeding ☐Finger stick / Insulin Pump management ☐Ventilator ☐Wheel Chair ☐Holter monitor ☐Feeding Chair	Diabetes: ☐Type I ☐Type II Other:_______________

Musculoskeletal	Neurological	Activity Restrictions	Dermatology
☐Hypotonia ☐Muscular Dystrophy ☐Scoliosis ☐Other_______________	☐Cerebral Palsy ☐Frequent headache ☐Migraines ☐Spina Bifida ☐Seizures ☐Sleep Disorder ☐Other	☐My child has a condition that warrants restriction of activities during school hours. (See page 2)	☐Eczema ☐Other

Gastrointestinal	Genitourinary	Dental	Medications
☐Constipation ☐IBS / Other:_____________ ☐Ileostomy ☐Colonoscopy ☐G-Tube ☐GJ-Tube	☐Bladder control problems ☐Urinary Tract Infections Other: _____________	☐Braces ☐Partials/ Dentures ☐Other	☐My child takes daily medication at home. ☐My child will need medication during school hours. (See page 2) ☐My child may need emergency medication during school hours. (See page 2)

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Explain any of the above on page 2.
Please identify any condition that warrants a restriction of student activity. Specify the nature and duration of the limitation and any other information that would be helpful to the school staff to assist your child in the space provided on page 2).

Please see back page…

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Please provide a list of all medications in the space provided below:

Medication	Dosage	Time	Frequency	Route	Reason

Special Diet/ Allergic Foods:

Any additional explanations of medical history:

Special Health Care Procedures:

Activity Restrictions during school hours:
(Specify the nature and duration of the limitation and any other information that would help the school assist your child)

Please provide the School Nurse with any important information to better help your child during medication administration or any medical treatment:

Parent Signature_____________________________________ Date:_______________________