

# CENTENNIAL SCHOOL DISTRICT SCHOOL HEALTH SERVICES HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN)

*The information provided is confidential. This information is necessary for the health and safety of the student to assist in promoting optimal healthcare to facilitate the academic success of each student. Thank you for your time.*

NAME OF CHILD: \_\_\_\_\_  
Last
First
Middle

ADDRESS: \_\_\_\_\_  
Street
City
State
Zip

HOME PHONE NUMBER: \_\_\_\_\_ E-Mail address \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ Grade \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

FATHER'S (GUARDIAN) NAME: \_\_\_\_\_ CELL #: \_\_\_\_\_  
Last
First

MOTHER'S (GUARDIAN) NAME: \_\_\_\_\_ CELL #: \_\_\_\_\_  
Last
First

CHILD'S PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_

CHILD'S DENTIST: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_

LAST SCHOOL ATTENDED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

**DISEASE/DISORDER HISTORY OR ILLNESS**

Please check any of the following that apply:

	Yes	No		Yes	No
Allergies/Environmental			Eating Disorder		
Allergies/Food			Endocrine Disorder		
Allergies/Insect Stings or Bees			Head or Spinal Injury		
Allergies/Latex			Headaches/Migraines		
Allergies/Medications			Hearing Problem		
Allergies/Other			Heart Defect or Disease		
Asthma/Breathing Disorder			Hepatitis or Liver Problem		
Behavioral Disorder			Hypertension		
Bladder/Kidney Disorder			Immune System Disorder		
Bleeding/Clotting Disorder			Mobility Limitation		
Bone/Joint/Muscular Disorder			Psychological/Emotional Problem		
Cancer			Scoliosis		
Convulsions/Epilepsy/Seizure			Skin Condition		
Developmental Disorder			Urinary/Bladder/Kidney Disorder		
Dizziness or Fainting			Speech Disorder		
Diabetes			Surgery or Hospitalization		
Dietary Restriction			Vision or Eye Disorder		
Digestive/Bowel Disorder			Other (explain below)		

- Was a medical evaluation performed for any condition/disorder checked 'yes': Yes \_\_\_\_\_ No \_\_\_\_\_

*Please turn page over and complete the other side*

DISEASE/DISORDER HISTORY OR ILLNESS (con't)

My child is under a Doctor's care for Asthma: Yes  No  If yes, medications taken: \_\_\_\_\_

\*An *Asthma Action Plan* form will need to be completed by the Doctor to ensure a safe school environment for your child.

My child is under a Doctor's care for a Severe Allergy to \_\_\_\_\_

Please describe the allergic reaction: \_\_\_\_\_

Epi-pen prescribed: Yes  No

\*An *Allergy Action Plan* form will need to be completed by the Doctor to ensure a safe school environment for your child.

My child is under a Doctor's care for Diabetes: Check type: Type 1 \_\_\_\_\_ Type 2 \_\_\_\_\_ \*A *Diabetic Medical Management Plan* will need to be completed by the Doctor to ensure a safe school environment for your child.

My child is under a Doctor's care for Seizures: Yes  No

If yes, describe type and medications taken: \_\_\_\_\_

\*A *Seizure Action Care* Form will need to be completed by the Doctor to ensure a safe school environment for your child

\* All Asthma/Allergy/Diabetes/Seizure care plan forms can be obtained from the School Nurse or downloaded from the school web site.

MEDICATION HISTORY

Does your child take medication on a daily basis (include homeopathic and nutritional supplements)? Yes  No

Please list all medications taken and what the medication or supplement is for:

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

SOCIAL HISTORY

Have there been any changes in your family during the past year, such as:

Separation, divorce, or remarriage? Yes  No

Death or serious illness? Yes  No

Any other situation, which may affect your son/daughter? Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

MISCELLANEOUS

Please list any condition and/or restrictions that your child may have which might limit his/her activities in school. Please include any comments that you think might be helpful:

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

YES  **NO CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for completing this form