THE JOHN CROSLAND SCHOOL

Student Health History Form

The following is a brief health history form which must be returned to the school nurse at the beginning of school. This information is essential for providing adequate treatment, in case of illness or injury, in meeting your child's health needs at school. If your child needs medication at school, a **MEDICATION CONSENT FORM** must be completed and returned to the office.

Student Name: _____ **Age**: _____
LAST FIRST MIDDLE

Medical Insurance Provider: _____ _____

Today's Date: _____ **DOB**: _____ ____ **M** ☐ **F** ☐ **Grade**: _____

Personal History (*Check all that apply; ever had or have now*):

☐ Arthritis	☐ Cancer	☐ Depression	☐ Headache	☐ Rheumatoid Disease
☐ AIDS/HIV	☐ Cardiac Abnormalities	☐ Diabetes	☐ Heart Disease	☐ Constipation
☐ Anemia		☐ Eating Disorder	☐ Insomnia	☐ Seasonal Allergies
☐ Anxiety	☐ Chronic Cough	☐ Emotional	☐ High Blood Pressure	☐ Kidney Disease
☐ Asthma	☐ Thyroid Disease	☐ Fainting/Dizziness	☐ Mental Illness	☐ Tuberculosis
☐ Bladder/Kidney Infection	☐ Congenital Anomaly	☐ Gastrointestinal Problems	☐ Migraines	☐ Blood Disorder
			☐ Frequent Colds	☐ Obesity
☐ Hearing Impairment	☐ Visual Impairment	☐ Seizures If yes, date of last seizure: _____		

Explain any checked boxes: _____
_____
_____

Past surgeries (*describe*): _____
Past serious illness/injury: _____

ALLERGIES (*check where applicable*):

☐ No Known Allergies	☐ Sulfa	☐ Animal
☐ Aspirin	☐ Codiene	☐ Insect
☐ Penicillin	☐ Food	☐ Other

If your child is allergic to food, animal or insects please specify : _____
_____
_____

Does your child require an epi-pen ? ☐ Yes ☐ No
Does your child wear a hearing aid? ☐ Yes ☐ No
Does your child wear glasses? ☐ Yes ☐ No

Student Health History (continued)

Please list **all** medications your child takes on a daily basis (even if not administered during school hours). List the medication, dosage, time given and what the medication is given for. This information is important to the physician who would be treating your child in an emergency.

Medication Name	Dosage	Time	This medication is being used to treat:

Hospital Preference: □ **CMC** □ **Presbyterian**

I GIVE MY CONSENT THAT IN THE EVENT OF A SERIOUS ACCIDENT OR EMERGENCY; MY CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL OR EMERGENCY ROOM.

_____ _____

Signature of Parent/Guardian **Date**