

**Cleveland County Health Department
School Health Services**

<p>For School Nurse Use Only Needs CP: Yes / No CP created/updated: _____ <input type="checkbox"/> School Staff Notified <input type="checkbox"/> Entered on Permanent Health Record <input type="checkbox"/> Entered on Daily Log</p>
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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 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 and return it to your child's school to be reviewed by the School Nurse / NP / PA.**

Student Name	Birthdate	Teacher	Grade
Address (Number, Street, City, State, Zip)		Phone Number	
Parent / Guardian(s)	Home Phone	Work Phone	Cell Phone
Physician Name and Address			Physician's Phone Number
Dentist Name and Address			Dentist's Phone Number

PLEASE CHECK BELOW IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING:

- 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: _____
- 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 your child take any medication on a daily basis? Yes _____ No _____

Please list the name, dosage, and time your child takes the medication:

Has your child ever had a serious illness, accident, or been hospitalized? Yes _____ No _____

If yes, please explain: _____

Please explain any of the above: _____

Will your child be taking any medication at school? Yes _____ No _____ If so, please review **Parent Information Regarding Medication in School** and complete the **Request for Medication to Be Given During School Hours Form**. You may obtain this information and medication form from your child's school.

Parent / Guardian Signature: _____ Date: _____

It is the practice of the School Nurse / NP / PA to develop or **update health care plans yearly** to assist school staff in caring for students with known health conditions. **If you have indicated above that your child has a health condition, please sign below to give permission for a Health Care Plan to be developed for your child.** This plan will be reviewed by school staff caring for your child and will be attached to your child's permanent school health record. If you have questions, please contact the School Nurse / NP / PA.

Parent / Guardian Signature: _____ Date: _____