STUDENT HEALTH HISTORY 2018 - 2019

Grade _____

To be completed by parent or guardian at time of enrollment

Name of Student:_____ **Female or Male (circle one)**

Student Birth Date: _____ **School:**_____

	Yes	No		Yes	No
ADD/ADHD Diagnosed by MD			Diabetes Type I or II		
Allergy to Food or Insect			Epinephrine for any Allergic Reaction		
Anxiety/Depression			Hearing or Speech Issue		
Asthma-Uses an Inhaler			Hearing Aid		
Bleeding Disorder			Heart Condition		
Bladder/Bowel Issue			Seizures		
Cancer			Stomach Issue		
Cystic Fibrosis			Vision: Contacts, Glasses or Cataract		
Dental Issue			Extracurricular Activities: (i.e., sports, band, orchestra, choir, etc.)		

If the answer to any of the above is **YES**, especially an allergy, please tell us more: _____

_____

Does your child have any special health care needs? **Yes** or **No** (please circle one)
If **Yes**, please explain: _____

What Medication does your child take regularly? _____

What Medication will your child take at school? _____

Are there any other medical problems that you would like to share with Health Services? _____

_____

A student requiring any over the counter or prescription medication at school <u>MUST</u> have a current school year, 2018-2019, Medication Request and Release Form on file. Written/signed Physician Authorization is <u>REQUIRED</u> for prescription medication to be given at school. Contact the school for a Medication Release Form or the form may be printed from the NPS website: https://www.normanpublicschools.org under Parents, Student Health, NPS Health Policies, Services and Forms – Student Health History 2018-2019*

Student health screenings are provided by the school nurses or other designated screening personnel to include: hearing, vision, height, weight, blood pressure, pulse, and dental.
Check one:

_____**Yes**, you ***may screen*** my child **OR** _____ **No**, you ***may not*** screen my child

I would like to schedule a meeting with the School Nurse: **Yes** or **No** (please circle one)

Date of last well child exam: _____ **Name of Physician:**_____

Parent email address: _____

Emergency phone numbers: Cell _____ **Other** _____

Parent/Guardian signature: _____ **Date:** _____