Pre-K Student Health History

Student health information within the school is limited to the information necessary to serve the student's educational and health interests

Student Name: _____ **Date**: _____

Please let us know your child's health needs by completing this form.

☐ **My child has no health problems which would affect his/her school day.**

OR

☐ **My child's health needs include the conditions checked (✓).**

- ☐ **Allergies** – List:_____
  Reactions:_____
  Is EpiPen Prescribed? ☐ Yes ☐ No (If yes, parent must provide EpiPen)
- ☐ **Bee Sting Allergy** – Reactions:_____
  Is EpiPen Prescribed? ☐ Yes ☐ No (If yes, parent must provide EpiPen)
- ☐ **Asthma** – Is inhaler used? ☐ Yes ☐ No If yes, how often? _____
  List medications taken for asthma:_____
- ☐ **Diabetes** – Medications taken:_____
  Special school day procedures:_____
- ☐ **Hearing Problem** – Please describe:_____
- ☐ **Vision Problem** – Wears glasses? ☐ Yes ☐ No Wears contacts? ☐ Yes ☐ No
- ☐ **ADD or ADHD Diagnosed** – Medications taken:_____
  Will medication be taken at school? ☐ Yes ☐ No (Complete 6.405 Exhibit B)
- ☐ **Bone/Joint Problem or Fracture** – Bone or joint:_____
  Is a brace worn? ☐ Yes ☐ No
- ☐ **Seizures** – Type:_____ Date of last seizure:_____
  Medication taken:_____
- ☐ **Episode of Loss of Consciousness** – Dates:_____
  School day treatment:_____
- ☐ **Emotional Concerns** – List:_____

List other reoccurring medical problems or illness you would like the school to know:_____

_____

Parent/Guardian Signature: _____
Please contact school nurse or system school nurse if conditions change.