

[School Site] Nurse
[Phone Number]

FALLBROOK UNION ELEMENTARY SCHOOL DISTRICT
Health History - Student Annual Update

School Year

Student Name: _____ Gender: _____

Teacher: _____ Grade: _____ Birthdate: _____

Father's Name/Legal Guardian: _____ Home Phone: _____ Work Phone: _____

Mother's Name/Legal Guardian: _____ Home Phone: _____ Work Phone: _____

***MUST CONTACT SCHOOL NURSE – ADDITIONAL FORMS NEEDED FOR SCHOOL.**

MEDICAL HISTORY	YES	NO	NOTES/EXPLANATION
Asthma			Inhaler Prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes*
Epilepsy/Seizures			Diastat Prescribed? <input type="checkbox"/> No* <input type="checkbox"/> Yes* Date of Last Seizure: _____
Severe Allergy			EpiPen/Medication Prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please Explain Below) If Yes, When was the EpiPen last used? _____
Food Allergy			EpiPen/Medication Prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please Explain Below) If Yes, When was the EpiPen last used? _____
Seasonal Allergies			Medication Required at school? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please Explain Below)
Diabetes			Medication Prescribed? <input type="checkbox"/> No* <input type="checkbox"/> Yes* (Please explain Below)
Medication Taken at Home?			Name of Medication: _____
Eye Problems/Glasses			Wears Glasses? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Last Eye Exam: _____
History of Recent or Serious Injury/Operation?			
Digestive Disorder			
Endocrine Disorder			
Hearing Problems			
Speech Disorder			
Urinary/Kidney Problems			
Heart/Blood Condition			
Orthopedic Problems			
Emotional Concerns			
ADD/ADHD			
Other:			

Known Allergies (Please describe trigger & allergic reaction): _____

Medications Needed at School* (Name, Time, Dose & Reason, Doctor's Note Required): _____

Any P.E. Restrictions? (Doctor's Note Required): _____

Are there any problems you would like to discuss with the school nurse? _____

Physician/Doctor: _____ Phone: _____

I hereby certify that the health history of this child is correct to the best of my knowledge and agree to the disclosure of my child's health information between FUESD and external health care professionals.