Student Health Information

The following information will be placed in your child's school health record and will be kept confidential between the nurse and the principal unless an emergency arises, or the nurse determines that the teacher(s)/staff has a need to know because of a specific health concern regarding your child. **Due to the Health Insurance Portability and Accountability Act (HIPAA) law, we request that you personally inform your child's teacher/staff of any health problems that your child has that could affect him/her during the school day.**

Student Name: _____Date of Birth _____

Does your child currently have or has he/she ever had any of the following conditions?

	(Circle)	Explanation
1. Allergies	yes no	_____
a. Asthma	yes no	_____
b. Skin problems(eczema, psoriasis)	yes no	_____
c. Food	yes no	_____
d. Bee sting	yes no	_____
e. Medicines	yes no	_____
2. Frequent colds and sore throats	yes no	_____
3. Arthritis	yes no	_____
4. Attention Deficit/Hyperactivity Disorder	yes no	_____
5. Birth defects/Developmental problems	yes no	_____
6. Bleeding problems, anemia	yes no	_____
7. Heart conditions	yes no	_____
8. Cystic Fibrosis	yes no	_____
9. Diabetes	yes no	_____
10. Eating disorders	yes no	_____
11. Endocrine disorders (thyroid, adrenal, growth dysfunction)	yes no	_____
12. Stomach, digestive, or bowel problems	yes no	_____
13. Kidney, bladder, or genital problems	yes no	_____
14. Hearing problems, earaches or tubes	yes no	_____
15. Headaches	yes no	_____
16. High blood pressure	yes no	_____
17. Immunosuppressive conditions	yes no	_____
18. Cancer	yes no	_____
19. Neurological disorders	yes no	_____
20. Bone/Joint/Orthopedic problems	yes no	_____
21. Seizures, epilepsy	yes no	_____
22. Mental Illness (depression, OCD, etc)	yes no	_____
23. Sickle Cell Disease	yes no	_____
24. Teeth problems	yes no	_____
25. Vision problems or color deficit	yes no	_____
26. Weight disorders	yes no	_____
27. Other	yes no	_____

Is your child under a doctor's care for any of the above? Yes No
Explain_____

Does your child have a Pennsylvania Access Card? Yes No

Student's Physician or other source of medical care: _____
Telephone Number:_____

Serious accidents:_____

Serious illnesses:_____

Operations:_____

Family Health History: Please circle any of the following diseases that the student's parents, grandparents, aunts, uncles, brothers, or sisters have had:

Allergies	Asthma	Color blindness	Deafness
Diabetes	Drug or alcohol addiction	Heart disease	Hepatitis
Kidney Disease	Mental Illness	Seizures	Tuberculosis

Other inherited or family diseases_____

Prenatal and Birth History

1. Problems, or illnesses, if any, mother had during pregnancy:_____
2. Did the mother take any medicines or drugs (other than vitamins) during the pregnancy? Yes no
3. Problems, if any, during birth:_____
4. Did the baby come on time?_____ Early?_____ Late?_____
5. Baby's birth weight?_____
6. Problems, if any, that the baby had while in the hospital:_____

Is your child on medicine at home? Yes No
Explain_____

Does your child need to take medications at school? Yes No
Explain_____

Does your child have any special health needs or problems or chronic conditions not already mentioned that the school should know?
Describe_____

****I give consent to share this information with the teacher(s)/staff if an emergency occurs or the nurse determines that it is necessary.**
****I understand that it is my responsibility to inform my child's teacher(s)/staff of his/her health problems.**

****Parent/Guardian's Signature_____Date_____**