THIS FORM MUST BE SIGNED AND RETURNED TO THE SCHOOL

School year 2017-18 | Dominion Academy Student Health History | Date:_____ Grade:_____

Dear Parent: Please provide a current health history so we can help your child benefit from his/her school experience. **Include all phone numbers where you may be reached and if they change during the year, call the school.**

Name: _____
Last First Middle

D.O.B.: _____ Sex: Male_____ Female _____

Address: _____
Street City State Zip code

Siblings at school:_____

Mother or guardian:_____ Phone:_____
Last First Middle home/ cell

Address:_____
Street City State Zip code

Employer:_____ Work Phone:_____

Father or guardian:_____ Phone:_____
Last First Middle home/ cell

Address:_____
Street City State Zip code

Employer:_____ Work Phone:_____

Child is in custody of: __Both ___Mother __Father __Other (please list) _____

Email address:_____

Person to call in case of emergency if parent/guardian is not available: **(Must be able to pick child up from school)**

Name: _____Relationship_____Phone:_____
Name: _____Relationship_____Phone:_____
Name: _____Relationship_____Phone:_____
Name: _____Relationship_____Phone:_____

Physician's Name: _____Physicians Phone: _____

Preferred Hospital: _____

PAST AND PRESENT – HEALTH PROBLEMS (please check and describe on other side)

☐ Yes	☐ No Allergies (describe on back)	☐ Yes	☐ No Diabetes	☐ Yes	☐ No Migraine headache
☐ Yes	☐ No Food: a. Benadryl b. Epi-pen	☐ Yes	☐ No Cancer	☐ Yes	☐ No Muscular dystrophy
☐ Yes	☐ No Bee sting a. Benadryl b. Epi-pen	☐ Yes	☐ No Eating disorder	☐ Yes	☐ No Thyroid condition
☐ Yes	☐ No Ear problem/hearing	☐ Yes	☐ No Hyperventilates	☐ Yes	☐ No Emotional disorder
☐ Yes	☐ No Orthopedic disorders	☐ Yes	☐ No Arthritis	☐ Yes	☐ No Spina bifida
☐ Yes	☐ No Asthma: a. Inhaler b. Nebulizer	☐ Yes	☐ No Colostomy	☐ Yes	☐ No Menstrual disorder
☐ Yes	☐ No Bleeding disorder/hemophilia	☐ Yes	☐ No Tracheotomy	☐ Yes	☐ No Vision glasses/contact
☐ Yes	☐ No Stomach spasms/ulcers	☐ Yes	☐ No headaches	☐ Yes	☐ No Cystic fibrosis
☐ Yes	☐ No Feeding tube/ G tube	☐ Yes	☐ No Scoliosis	☐ Yes	☐ No Cerebral palsy
☐ Yes	☐ No Seizures/convulsions	☐ Yes	☐ No Catheterization	☐ Yes	☐ No Heart Condition
☐ Yes	☐ No Sickle-cell anemia	☐ Yes	☐ No BP disorder	☐ Yes	☐ No Other_____

Parent/Guardian must provide benadryl, epi-pen, inhaler or nebulized medication

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HEALTH PROBLEMS

Please explain any :yes" answer to prevent the previous questions. _____

_____

_____

_____

_____

ALLERGIES

List all known allergies to food, environment, medication or other. Describe reaction and treatment. _____

_____

_____

_____

_____

MEDICATIONS

All medications that may need to be administered during the school day must be provided to the school attendant by the parent. Written parent permission and doctor's order as needed is required before medication will be administered at school. See the school handbook for further information.

Is your child taking any medications? ____ Yes or ____ No If yes, please describe below: Prescription and non-prescription drugs – identify drug and condition requiring drug: _____

_____

_____

_____

_____

- All medication over – the – counter and prescribed must be provided by the parent.
- Written permission is required before medication may be administered.
- Keep you child home if he/she has:
    a) an oral temperature greater tan 100.4* F, 38* C
    b) vomiting
    c) diarrhea
    d) rash with fever
    e) appears severely ill
    f) infected with pink eye
- Call the school if your child is sick
- Keep school immunization records up – to – date.

By signing below I acknowledge that the information on both side of this form are correct to the best of my knowledge.

_____

Signature of Parent / Guardian Date