NORTHWEST ALLEN COUNTY SCHOOLS PERSONAL HEALTH HISTORY

Student's name: _____ Gender: ❒ Male ❒ Female
Last *First* *M.* Grade _____ Room _____

Date of Birth: _____ Primary Language: _____

Primary Address: _____
Street *City* *Zip*

Student lives with: ❒ Both Parents ❒ Mother ❒ Father ❒ Other: Explain:

Primary Parents/Guardian:

Mother/Guardian: _____
Last *First* *M.*

Daytime Phone: Work/Home Phone: _____ Cell Phone: _____ E-Mail: _____

Father/Guardian: _____
Last First M.

Daytime Phone: Work/Home Phone: _____ Cell Phone: _____ E-Mail: _____

MEDICAL

Does your child have a doctor? ❒ Yes ❒ No Medical Coverage: ❒ Private ❒ Medicaid/Hoosier Health Wise ❒ No Insurance

Physician's name _____ Phone : _____ Hospital Preference: _____

MEDICAL HISTORY **Have You Been Told By A Physician or Health Care Professional That Your Child has: (*Check all that apply*)**

❒ Asthma ❒ Exercise Induced Asthma ❒ Inhaler required at school ❒ Self-Carry Inhaler (requires doctor's order)	❒ Heart disease ❒Murmur ❒ as infant ❒ recent or under treatment ❒ Heart problem with restrictions- explain on other side
❒ ADD ❒ ADHD ❒ On ADD/ ADHD Medications, see back ❒ Asperger's Syndrome ❒ Autism❒	❒ Lung Disease- explain on other side ❒ Tuberculosis ❒ latent ❒ active
❒ Arthritis ❒ Rheumatoid ❒ Juvenile Arthritis	❒ Orthopedic/bones ❒ disease ❒ Prosthesis
❒ Bladder/Kidney concerns-explain on other side	❒ Psychological/Psychiatric – list medications and specific diagnosis on back
❒ Blood/Clotting ❒ Hemophilia ❒ Van Willebrand ❒ Anemia ❒ Other	❒ Seizures ❒ from fever ❒ Epilepsy ❒ Unspecified ❒ Shunt
❒ Cancer ❒ Leukemia ❒ Other	**ALLERGIES**
❒ Crohn's disease ❒ Stomach/Bowel disease-explain on other side	❒ Insect/Bee Sting ❒Local (swelling at site) allergy to bees ❒ Requires hospital/ Epi Pen ❒ Seasonal (requiring medication) ❒ Hay fever (requiring medication)
❒ Diabetes ❒ Type I ❒ Type II ❒ Metabolic Syndrome	
❒ Food intolerance ❒ Lactose Intolerance	❒ Latex requiring hospital/ Epi Pen ❒ Latex (not life-threatening)
❒ Head Injury Recent Date: ❒ Headaches (nonspecific) ❒ Migraine ❒ Deafness ❒ Blindness ❒ Prosthetic eye	❒ Animals – explain on other side ❒ Food -life threatening -requiring Epi Pen _____ Specify on back. ❒ Medication Allergies: Specify_____ _____
❒ Diet Restrictions-explain on other side ❒ Eating Disorder ❒ Obesity ❒ Underweight ❒ Anorexia	

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. This will be done only on a "need to know" basis, in a confidential manner. I agree that the school nurse may consult with my child's family physician (s) about the above medical condition (s). I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of my child. I will furnish the school with a current telephone number and address in case of an emergency. The above permission will be valid from the date below, unless I revoke the permission in writing. In case of an emergency involving your child, it is the policy of this school corporation to render first aid treatment while contacting parents for further instructions. Only after reasonable efforts to reach the parents without success will we call a doctor, and only in extreme cases will your child be taken to a hospital or 911 contacted.

Parent / Guardian Signature_____Date_____

Please give details for all that are marked YES on side one <u>that may impact</u> your child's routine at school.

Most medications may be taken at home. Will your child be *required* by a physician to take medication during school hours? ❒ Yes ❒ NO				
All medication taken at school will require an additional signed medication permit on file <u>PRIOR</u> to giving medication at school.				
List Medication/s your child takes on a daily basis.				
Medication Name	Amount	Time Taken	Doctor Prescribing Medication	Condition
1.			1.	
2.			2.	
3.			3.	
4.			4.	
5.			5.	

❒ My child had Chickenpox Disease on:
Month_____ Year _____

❒ My child has NOT had Chickenpox Disease

❒ My child was hospitalized overnight Date: _____ Reason _____

My child is Required to wear: ❒ Glasses ❒ Contacts Date of last vision exam: _____ ❒ Hearing Aid

Does your child require any ongoing medical/emotional care or treatment? ❒ Yes ❒ NO

Condition	Physician Caring for Condition	Requesting a Health Care Plan for this Condition	
		❒ Yes	❒ No
		❒ Yes	❒ No
		❒ Yes	❒ No

Other:

***Important health note!**: An additional, specific "**Individual Health Care Plan**" should be in place for students with Asthma, Diabetes, Allergies (food, insect, etc.), Seizures, Cardiovascular conditions, Cancer or other special health concerns or conditions. Many of these require a doctor's signature. Please see available Care forms on the Health Services page of NACS website or if preferred, contact your school nurse as soon as possible to compete the plans. <u>Plans should be completed and in place before the first day of school.</u>*