TEACHER:_____

ESTACADA SCHOOL DISTRICT

Health History Form 2016-17

GRADE:_____

Please complete this form and return it to the school office.

Student Name_____DOB_____School: CR RM EMS EHS
Parent Name(s)_____Phone _____
Medical Insurance Company_____Policy #_____
Physician(s)_____Phone_____
Hospital Preference_____

☐ **My child does NOT have any medical concerns, conditions, or illnesses.** Please continue to the reverse side of this form to **read and sign parental consent.**

Check any condition or illness that applies to your child

My child has:

- ☐ **Allergies to food:** _____
- ☐ **Allergies to bee stings.**
- ☐ **Allergies to medicine**: _____
- ☐ **Allergies to other (seasonal, latex, etc.)** _____

Is this allergy life-threatening? ☐Yes ☐No ☐ Unknown

When exposed to allergens listed above, my child experiences: ☐ Anaphylaxis ☐ Local swelling ☐ Upset stomach

☐ Behavior problems ☐ Vomiting ☐ Hives ☐ Other: _____

Does your child require emergency medication to control this allergy? ☐ Epi Pen ☐ Other: _____

*It is parent's responsibility to bring emergency medications to the school for your child. The school does not provide any medications.

Does child need special diet because of the allergy? ☐ Yes ☐ No

*Doctors orders are needed to make any substitutions in food choices if student is part of school lunch program (for example, substituting soymilk for regular milk.)

☐ **ASTHMA**: ☐ Exercise induced ☐ During colds/flu ☐ Seasonal

Under Physician care now? ☐ Yes ☐ No

☐ **Takes medication for Asthma:** Name medication(s):

☐ **ADD/ADHD**

☐ **Takes medication for ADD/ADHD:** Name medication(s):

☐ **DIABETES (hyperglycemia): Type:** _____

☐ **Diet controlled**

☐ **Is your student independent with diabetes care?** ☐Yes ☐ No ☐Partially, still needs some help/guidance

☐ **Takes medication/insulin:** Name medication(s):

☐ **DIGESTIVE Disorders:**

☐ **Takes medication for digestive disorder:** Name medication(s):

☐ Serious **HEAD INJURY:**

☐ **HEARING** problems: ☐ Uses hearing aid

☐ **HEART CONDITION:**

Under physician care for this condition? ☐ Yes ☐ No

Any physical restrictions?

☐ **HIGH BLOOD PRESSURE (hypertension):**

☐ **Takes medication for high blood pressure:** Name medication(s):

TEACHER:_____

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☐ **KIDNEY or BLADDER disorder:** ☐ **Takes medication this disorder:** Name medication(s):
☐ **MIGRAINES:** ☐**Takes medication for migraine:** Name medication(s):
☐ **MUSCLE/BONE/MOBILITY disorder:**
☐ **PSYCHIATRIC diagnosis:** ☐ **Takes medication for this condition:** Name medication(s):
☐ **SEIZURE/EPILEPSY:** ☐ **Takes medication for Epilepsy:** Name medication(s):
☐ **VISION** problems: ☐ Glasses ☐ Contacts
☐ **OTHER medical condition(s) not listed:**

HEALTH HISTORY & EMERGENCY INFORMATION PARENTAL CONSENT

Estacada School District makes provision for health record, nursing consultation, emergency care treatment, and yearly non-invasive screenings (i.e. hearing, vision). Any parent wishing to opt their child out of a screening must do so in writing. Temperature screening will also be done if deemed necessary. Parent/guardian has the responsibility of listing any allergies or major health concerns on the reverse side of this card.

In case of serious illness or injury where immediate care is needed, the school, or its representative, has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where (s)he is unable to remain at school, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that one of the emergency contact persons listed on the registration card be contacted and requested to care for my child. In the event no emergency contact person designated is available, emergency medical services may be contacted for further assessment and possible transport and treatment. I understand that I must notify the school if there are any changes in this health history and emergency information.

I understand that certain educational records of my child will be shared with the District's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such records.

Signature of Parent or Guardian:_____

Date: _____