

# Annual Student Health History Update/ TUSCOLA HIGH SCHOOL (2011-12)

Student's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Telephone (W) \_\_\_\_\_ (H) \_\_\_\_\_ (C) \_\_\_\_\_

Address: \_\_\_\_\_ Student's Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Bus Rider: \_\_\_\_\_ # \_\_\_\_\_ Car Rider: \_\_\_\_\_ Driver: \_\_\_\_\_ School Nurse Use Only: \_\_\_\_\_

## Please Check (✓) Medical Conditions that apply to your child:

| ✓ CONDITION  | TREATMENT NEEDED   | EXPLANATION (if needed)   |
|--|--|---|
| <input type="checkbox"/> <b>ALLERGIES</b><br>BEES: _____<br>FOOD: _____<br>MEDICATION: _____<br>OTHER: _____   | Does your child take medication for allergies?<br><br>What treatment is necessary? | Epi-Pen? _____ Benadryl? _____<br><br>Does student have necessary meds at school?           |
| <input type="checkbox"/> <b>ASTHMA</b>   | Inhaler? _____<br>Type: _____  | Does student carry Inhaler at school?   |
| <input type="checkbox"/> <b>DIABETES</b><br>TYPE 1: _____<br>TYPE 2: _____   | Does your child use an Insulin Pump?   | Is your child on any other medication?<br><i>(if yes please list medication and dosage)</i> |
| <input type="checkbox"/> <b>EPILEPSY/SEIZURES</b>  | How often does your child have a seizure?  | Is your child on medication?<br>At home? _____ At school? _____                             |
| <input type="checkbox"/> <b>HEART DISEASE</b>  | What condition does your child have?   |   |
| <input type="checkbox"/> <b>PHYSICAL DISABILITY</b>  | Please describe any physical disabilities & limitations                            |   |
| <input type="checkbox"/> <b>ANY OTHER HEALTH PROBLEMS</b><br><i>(Please be specific, if need more room, please use other side of paper)</i><br>Attach any medical documentation to this sheet. |  |   |

**\*\*Parent must supply school with any medicines the child needs. PARENT MUST BRING MEDICINE TO SCHOOL IN ITS ORIGINAL CONTAINER.** Written permission and instructions for giving medications must be on file at the school. Forms are available in the school office. *Your signature confirms the above information is accurate and can be used by the school system and the school nurse to update your child's health record. It also gives the school nurse permission to perform MINIMAL screening (temperature, ice, bandages, etc) on your child in the event of illness or injury at school.*

\_\_\_\_\_  
Parent and /or Guardian Signature

\_\_\_\_\_  
Date