HEALTH HISTORY

The school district considers this to be personal, confidential information that will be treated in a discreet manner. The form may be reviewed by the school nurse, the classroom teacher, the building administrator, and other educators on a need to know basis.

Today's Date ______________________

Name ____ Date of Birth ______________________
(last) (first) (middle)

School ______________________ Teacher ______________________ Grade ________

Physician ______________________________ Dentist ______________________________

Please fill in any information that is applicable, Please use the back side if necessary for additional information

1) Asthma medications ________________ symptoms ________________
2) Allergy specify ________________ symptoms ________________
3) Diabetes insulin/snacks ________________ symptoms ________________ age of onset ________
4) Seizures medications ________________ symptoms ________________ age of onset ________
5) ADD/ADHD ________________ medications ________________
6) Visual problems ________________ glasses/contacts ________________
7) Hearing problems ________________ frequent ear infection ________________ hearing aids ________________
8) Heart conditions ________________ specify restrictions ________________
9) Congenital/Chronic conditions ______________________________
10) Chicken Pox (date) ________________
11) Serious injuries (list) ______________________________
12) Operations (list) ______________________________
____
13) Other ______________________________
____
____
14) Special seating, bathroom privileges, restrictions ______________________________
____
15) Please list medications your student takes both at home and school. **MEDICATIONS GIVEN AT SCHOOL MUST BE CHECKED INTO THE OFFICE.**
____
____
16) Immunizations administered within the past year: ______________________________
(Please provide documentation)

______________________________ ______________________________
Individual Completing Form Relationship to Student

____
Home Phone

____
Work Phone

Health History 12/08 - WH #3176

imMTrax Consent Form for Children

Child's Name:______________________________ Sex: M__ F__ Date of Birth:__________

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Parent/Guardian Signature: ______________________________

Date: ______________________________

Revised (10/2012)