

**USD 384 Health History**  
**New Student and Yearly Update**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Family Physician \_\_\_\_\_ Clinic name/Phone: \_\_\_\_\_

Is Student being cared for by a physician at this time? Yes \_\_\_ No \_\_\_ If yes, please explain \_\_\_\_\_

Please List and explain any **ALLERGIES** (food, bee stings, seasonal, medications, etc.) Include any required medication and/or Epi-Pen \_\_\_\_\_

Please List all **Daily Medications** and reason (at home and/or at school) \_\_\_\_\_

Please List all **Occasional Medications** and reason (at home and/or at school) \_\_\_\_\_

*Note: all Prescription Medications, including Inhalers, needed during school day and/or activities need a written order from licensed physician and parent/guardian signature. All Over-the-Counter Medications need a signed form by parents/guardian. All Medications, Inhalers, Epi-pens, etc. need to be checked into the school office.*

Has your student had or currently have any of the following:

ADD/ADHD	Yes No	Heart or Blood disease, high blood pressure	
Asthma	Yes No	Hearing Loss	Yes No
Bone/Muscle Condition	Yes No	Nosebleeds	Yes No
Chronic Ear/Throat infection	Yes No	Physical Disability	Yes No
Concussion/Head Injury	Yes No	Urinary/Kidney/Bowel Problems	Yes No
Frequent Headaches	Yes No	Vision Problems	Yes No
GI/Stomach/Intestinal problems	Yes No	Glasses _____ Contacts _____	
Diet Restriction/Special Diet Needs	Yes No	Other Condition not listed	Yes No

Please explain any and all YES answers: \_\_\_\_\_

\_\_\_\_ I hereby give permission for my child to participate in school-provided Vision, Hearing and Dental screenings as available.  
 YES NO

\_\_\_\_ I hereby give my consent for my child receive medical care during regular school hours and/or school related activities for any urgent, non-emergency problems.  
 YES NO

\_\_\_\_ I hereby give permission for the school nurse to exchange my child's immunization information with the health department, physician's office and/or the Kansas Immunization Registry (KSWebIZ) for the purpose of assessment and reporting.  
 YES NO

\_\_\_\_ I understand the information I have provided is considered confidential. I give my permission for the school nurse to share this information on a need-to-know basis with USD 384 staff who will be in direct contact with my child ie. class room teachers, substitutes, paras, administration, office staff, bus drivers, cafeteria staff, coaches, etc.  
 YES NO

If there are specific school staff with whom you do NOT want your child's health information shared with, please specify by name: \_\_\_\_\_

\_\_\_\_\_  
 Signature Parent/Legal Guardian

\_\_\_\_\_  
 Date

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Child's Name \_\_\_\_\_ Age: \_\_\_\_\_

Is Your Child being cared for by a doctor at this time? \_\_\_YES \_\_\_NO If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Please list and explain any ALLERGIES (food, bee stings, seasonal, medications, etc.) Please list any required medications and/ or Epi-Pen use: \_\_\_\_\_  
\_\_\_\_\_

Please list any DIET RESTRICTIONS ( a note from your Doctor is required if your child has any special dietary needs or restrictions ) \_\_\_\_\_  
\_\_\_\_\_

Please list and explain any past or current ILLNESS or HEALTH PROBLEMS/CONDITIONS  
\_\_\_\_\_  
\_\_\_\_\_

Please list all DAILY MEDICATIONS and reason for (taken at home and/or at school) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all OCCASIONAL MEDICATIONS and reason for (taken at home and/or at school) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any other health issues or concerns you may have for your child while attending pre-school  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ \_\_\_ I give permission for my child to participate in Vision, Hearing and Dental Screenings.  
YES NO

\_\_\_ \_\_\_ I give permission for the school nurse to exchange my child's immunization information  
YES NO with health department, physician's office and/or the  
Kansas Immunization Registry (KSWebIZ).

\_\_\_ \_\_\_ I give permission for the school nurse to share my child's health information on a  
YES NO need-to-know basis with Pre-School staff and any USD 384 staff who will  
be in direct contact with my child ie-class teachers, substitutes, para,  
administration, bus drivers, etc. in order to provide a safe and healthy  
environment for my child's education.

I do NOT want my child's health information shared with \_\_\_\_\_

\_\_\_\_\_  
Signature Parent/Legal Guardian

\_\_\_\_\_  
Date

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