

St. Paul Lutheran School

Health History Information 2020-2021

Please complete both sides.
The information on this form is confidential.

Grade _____

Student Name _____ Birthdate _____

Address _____

Home Number _____ Cell Number _____

Work Number _____

Parent(s)/Guardian Name(s) _____

Physician/Specialist & Phone Number _____

ASTHMA:

1.) Has your child been diagnosed with asthma? _____

Date of last attack _____

2.) What causes an attack in your child? Allergies ___ Infections ___ Weather ___ Exercise ___

Anything not listed: _____

3.) Usual symptoms: _____

4.) Will your child keep an inhaler in the health office for use during school? Yes _____ No _____

(If yes and medication is to be given during school hours, medication must be provided by parent and we will need a medication permission form signed by providing physician.)

ALLERGIES (including food):

1.) Has your child been diagnosed with any kind of allergies? Yes _____ No _____

2.) What, specifically, causes an allergic reaction in your child? _____

3.) Usual or past reactions? Redness ___ Swelling ___ Itching ___ Hives ___ Rash ___

anything not listed: _____

4.) Does your child use any medication(s) for symptoms? _____

(If yes and medication is to be given during school hours, medication must be provided by parent and we will need a medication permission form signed by providing physician.)

DIABETES:

1.) Which type does your child have? Type I _____ Type II _____

2.) Age of diagnosis? _____

3.) Does your child use an insulin therapy pump? Yes _____ No _____

4.) Does your child use injections? Yes _____ No _____

Is your child comfortable with self injecting? Yes _____ No _____

(If yes and medication is to be given during school hours, medication must be provided by parent and we will need a medication permission form signed by providing physician.)

HEART CONDITION:

1.) Describe problem: _____

2.) Any restriction(s): _____

3.) Any medication(s): _____

(If yes and medication is to be given during school hours, medication must be provided by parent and we will need a medication permission form signed by providing physician.)

SEIZURE DISORDER:



- 1.) Type of seizures: _____
- 2.) Age of diagnosis: _____ Average length of seizure _____
- 3.) Date of last seizure _____ Does your child take anti-seizure medication? _____
- 4.) Name of medication(s) taken: _____

(If yes and medication is to be given during school hours, medication must be provided by parent and we will need a medication permission form signed by providing physician.)

OTHER HEALTH NEEDS OR CONCERNS: (includes ADHD, dental problems, dentures, orthopedic conditions, mental health concerns, etc):

Any medications taken at home that you have not already listed: _____

Any medication(s) that will need to be kept at school: _____

(If yes and medication is to be given during school hours, medication must be provided by parent and we will need a medication permission form signed by providing physician.)

VISION:

Does your child wear glasses? Yes ___ No ___ Does your child wear contacts? Yes ___ No ___

HEARING:

Has your child ever been screened by an audiologist? Yes ___ No ___

Does your child have a hearing impairment? Yes ___ No ___

Does your child wear a hearing device? Yes ___ No ___

Does your child have hearing implants? Yes ___ No ___

Please note:

As the parent, you are primarily responsible for administering medication to your child. However, we are aware that you cannot always do so and may wish to have the school personnel administer or supervise your child self-administering medication. To schools, a medication is any drug purchased over the counter (for example, Tylenol, cough syrup, cough drops), as well as those prescribed by a doctor. Our schools maintain no supply of medications.

Medications are to be supplied in an original container, be clearly marked with the students name and correct dosage. At school, medications will be stored in a locked cabinet and accessible only by school personnel. If a student is to have a medication on his/her person, such as an inhaler or epinephrine auto injector, there will need to be a doctor's order for this. Requests for medication administration are good for a school year only and must be renewed each school year.

MEDICATION PERMISSION SECTION:

I, the parent / guardian of this student, authorize St. Paul Lutheran School and its employees, in my behalf and stead, to administer or to allow my child to self-administer with supervision lawfully prescribed medication. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than the school nurse and specifically consent to such practice. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against St. Paul Lutheran School and its employees, arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify St. Paul Lutheran School and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication(s).

Printed Parent/Guardian Name(s)

Parent/Guardian Signature(s)

Date

**Should you have any further questions or requests of the school office personnel, please do not hesitate to contact the school.*