St. Paul Lutheran School

Health History Information
2019 - 2020

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:

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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.*