Santa Fe Trail USD #434

Student Health History Form

THIS INFORAMTION WILL BE HELD IN CONFIDENCE AND DISCLOSED TO SCHOOL PERSONNEL TO THE EXTENT NECESSARY TO PROTECT THE HEALTH OF THE STUDENT. IT IS IMPORTATN THAT THE QUESTIONS BE ANSWERED COMPLETELY AND ACCURATELY.

STUDENT NAME:

Date of Birth: Grade: Male / Female

Parent/Guardian Name / Relationship / Contact number (Please list primary contact first):
1._____
2._____
3._____
4._____

Student lives with: ____ Both Parents ____ Mother ____ Father ____ Guardian

Is the student new to the district: No Yes, if yes – list school last attended:

ALLERGIES:

- To Medications No Yes, please list _____
- To Bee Stings No Yes, what is the reaction _____
- To Latex No Yes
- Allergy to foods No Yes, please list _____

**if allergy to foods a meal modification form is needed.
**if student uses Epi-Pen, please complete additional paperwork.

HEALTH CONCERNS: please check any health conditions listed below that your student has

	Vision: Glasses or Contacts		High Blood Pressure		Brain/Neurological Disorder
	Hearing Impaired/Hearing Aids		Headaches/Migraines		Anemia/Blood Disorder
	Speech		Seizure Disorder		Surgery
	Dental		Frequent Sore Throats		Asthma (additional paperwork)
	Genetic Disorder		ADD/ADHD		Skin Disease
	Frequent Ear Infections		Cancer		Diabetes/Endocrine Disorder
	Eating Disorder		Prosthesis		Developmental Delay
	Cardiovascular Disease		Urinary/Kidney Disease		Stomach/Intestinal Disorder
	Musculoskeletal Disorder		Degenerative Disorder		Autoimmune Disorder
	Seasonal Allergies		Other:		Other:

Please fully explain any answers checked above.

_____
_____
_____

Does the above health concern require special attention at school? ____ No ____ Yes
Describe any ongoing behavioral, emotional or psychological concerns you have about your child: _____
_____
Any other factors that the school nurse, counselor or your child's teacher(s) should know: _____
_____
Any current Medications: _____
_____

*Medications to be taken at school require additional paperwork.

DOCTOR VISITS : Has the student been seen during the last year?

____ Physical Exam Date: _____ Doctor: _____
____ Dental Exam Date: _____ Doctor: _____
____ Vision Exam Date: _____ Doctor: _____

I give my permission for confidential and discreet use of the above information to meet my child's health and educational needs at school
Parent/Guardian Signature: Date:

Updated 1/2023