

Mendota District #289- Health History Form

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

ASTHMA:

1. Has your child been diagnosed with asthma? Yes No
2. Does your child take any medications for asthma? Yes No
3. If so, what medications are ordered? _____
4. Does your child need to take any medications for asthma at school? Yes No
5. What triggers your child's asthma: _____
6. Usual symptoms which occur: Wheezing _____ Coughing _____
Chest discomfort _____ Difficulty Breathing _____

ALLERGIES:

1. What causes an allergic reaction in your child? _____
2. Usual or past reactions: redness _____ swelling _____ itching _____ hives _____ rash _____
swelling of face or tongue _____ difficulty swallowing, talking, or breathing _____
3. Does your child require an epi-pen? Yes No
4. Does your child require any other medications for allergies, if so please name: _____
5. Does your child require medication for allergies at school: Yes No

SEIZURE DISORDER:

1. Type of seizure: _____
2. Age of diagnosis: _____ Date of last seizure: _____
3. Does your child take anti-seizure medication? Yes No
4. Name of medication: _____

DIABETES:

1. Age of diagnosis: _____ Type of insulin: _____ Carbohydrate counting: Yes No
2. Usual reaction for hypoglycemia: _____
3. Usual reaction for hyperglycemia: _____

HEART CONDITION:

1. Describe problem/restrictions: _____
2. List medications, if any: _____

OTHER HEALTH NEEDS OR CONCERNS: (include ADHD, dental problems, orthopedic)

GLASSES OR CONTACTS: Yes No Near _____ Far _____

PESTICIDES:

Is this child sensitive to pesticides and should be notified before pesticide applications? Yes No

Your signature below indicates your permission to share health information with appropriate school personnel.

PARENT/GUARDIAN SIGNATURE

Date: _____

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to make the necessary arrangements needed for my child.

Student Physician: _____ Student Dentist: _____

Hospital of Choice: _____

PARENT/GUARDIAN SIGNATURE

Date: _____