



FOREST HILLS PUBLIC SCHOOLS HEALTH HISTORY

School Year _____

The following is a brief health history form. The information is essential for the school to be properly prepared to take care of any special health needs your child may have during the school day. Please be assured that this information will be guarded with confidentiality and only shared with school personnel as necessary. Please keep this information up to date. Staff conference may be required or can be requested by parent/guardian.

Student Name _____ Date of Birth _____ Grade _____ School _____

PLEASE CHECK BELOW IF YOUR CHILD HAS ANY OF THE FOLLOWING: *No medical information to report*

<input type="checkbox"/> ADD/ADHD Medications? <input type="checkbox"/> Home <input type="checkbox"/> School	<input type="checkbox"/> Depression
<input type="checkbox"/> Behavioral/Emotional	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Headaches/Migraines Triggers:
<input type="checkbox"/> Bowel/ Bladder	<input type="checkbox"/> Hearing Problems Hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Visually Impaired Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Special Diet

Other

Skilled Procedures: Tube Feeding Catheterization Tracheotomy/Suctioning Other

Physical Restrictions (Physician's note required):

Medication required at school (Medication form required):

Please explain any of the above:

The following conditions require an Emergency Action Plan with signatures from parent/guardian and health care provider.

<input type="checkbox"/> Allergies: <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Food Food List _____ Reaction _____ <input type="checkbox"/> Medication at school <input type="checkbox"/> No medication required Location of Medication: <input type="checkbox"/> Student <input type="checkbox"/> Office <input type="checkbox"/> EpiPen <input type="checkbox"/> Auvi-Q <input type="checkbox"/> Oral Medication	<input type="checkbox"/> Asthma: Triggers: <input type="checkbox"/> Exercise <input type="checkbox"/> Environmental Other _____ <input type="checkbox"/> Medication at school <input type="checkbox"/> No medication required Location of Medication: <input type="checkbox"/> Student <input type="checkbox"/> Office <input type="checkbox"/> Self-administered
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/> Requires daily intervention from school staff <input type="checkbox"/> Self-managed	<input type="checkbox"/> Seizure Disorder: Medication? <input type="checkbox"/> Home <input type="checkbox"/> School Location of medication: <input type="checkbox"/> Student <input type="checkbox"/> Office <input type="checkbox"/> History of seizure, but not presently medicated Date of last seizure _____

Parent/Guardian Signature _____ Date _____