Student Health History Form and Release of Information—School Year 20_____

Student Name (Print First and Last name) _____ DOB _____ Grade_____

Your student's heath history is important to provide the best care at Shepherd School. It is the responsibility of the parent/guardian to notify the school of new or existing health concerns. If your student is prescribed medication or requires a treatment at school, it is the responsibility of the parent or guardian to notify the school nurse and provide the medication or necessary equipment for use at the school.

My child has the following (NEW or EXISTING) medical condition(s). (Check all that apply)

Head
- ☐ Concussion
- ☐ Migraines (diagnosed)
- ☐ Frequent Headaches
- ☐ Seizures
- ☐ Other _____ _____

Eyes
- ☐ Vision Concerns
- ☐ Glasses
- ☐ Contacts
- ☐ Vision Loss/ One eye L___R___ or Both eyes_____
- ☐ Other_____ _____

Skin
- ☐ Skin concerns e.g._____ _____ _____
- ☐ Other_____ _____

Ear/Nose/Throat/Mouth
- ☐ Frequent earaches/ infections
- ☐ Tubes in place
- ☐ Hearing loss/condition
- ☐ Speech problems
- ☐ Swallowing problem
- ☐ Dental Pain or concerns
- ☐ Other_____ _____

Heart/Lungs
- ☐ Asthma
- ☐ Heart condition
- ☐ Cystic Fibrosis
- ☐ High Blood Pressure
- ☐ Other_____ _____

Emotional/Behavioral/Psychological
- ☐ Mental/emotional concerns
- ☐ ADD
  Medication: _____
  Dose: _____
- ☐ ADHD
  Medication: _____
  Dose: _____
- ☐ Other_____

Endocrine/Blood
- ☐ Diabetes/Type 1
- ☐ Diabetes/Type 2
  - ☐ Pump
  - ☐ Injection
  - ☐ Meds
- ☐ Blood disorder
- ☐ Other_____ _____

Bone/Muscle/Joint
- ☐ Muscular concerns
- ☐ Knee, back, bone or joint concerns
- ☐ Scoliosis
- ☐ Cerebral palsy
- ☐ Spina Bifida

Abdomen/Intestinal/Urinary
- ☐ Frequent stomach aches
- ☐ Urinary or bowel concerns
- ☐ Other_____ _____

Allergies
- ☐ Anaphylactic/ foods
- ☐ Anaphylactic/ nuts
- ☐ Anaphylactic/ peanuts
- ☐ Anaphylactic/ stings
- ☐ Allergy, Airborne
- ☐ Allergy, Animal
- ☐ Allergy, Medication
- ☐ Allergy, Food
- ☐ Allergy, Latex
- ☐ Lactose Intolerance

List specific allergy(ies):

_____
_____
_____

Chromosome/Genetic
- ☐ Down Syndrome
- ☐ Other_____ _____

Other Concerns
- ☐ _____ _____

☐ **My Child has NO (new or existing) health concerns.**

(If you check this box, you agree to communicate with the school regarding new health concerns during the school year)

My Child will require the following medication types given during the school day/year (check all that apply)

- ☐ Long-Term Prescribed Medication

Medication form must be completed by the parent/guardian AND healthcare provider, and medication delivered in a properly labeled pharmacy container.

- ☐ OTC/Over the counter Medication

To have OTC medication at school, a parent must complete a medication form and provide the medication in the original container AND be age appropriate dosage.

My child will require the following emergency medication(s) at school, check all that apply (parent/guardian must provide medication AND fill out medication form)

- ☐ Epinephrine (EpiPen)
- ☐ Antihistamine (e.g. Benadryl)
- ☐ Rescue Inhaler
- ☐ Glucagon
- ☐ Diazepam
- ☐ Midazolam

***Release of Information**: The school nurse has permission to share information with school staff as she determines appropriate for my child's safety. ___Yes ___No

The school nurse has permission for mutual exchange of information and records with my child's health care provider:

Childhood Immunizations ___Yes ___No Prescribed Medications ___Yes ___No

_____ _____ _____

Parent/Guardian Signature | Please Print Name Here | Date

(04/2021 HM)

TURN OVER

Will your child be taking medication at school? YES ____ If so, please fill out the required form.
PLEASE GET THE FORM FROM THE NURSE'S OFFICE

Is your child on medication? YES ____ NO ____ If so, please list the name and the dosage below:

MEDICATION NAME	DOSAGE

Child's Doctor: _____

Child's Dentist: _____

Hospital Preference: St. Vincent _____ Billings Clinic _____

It is understood a conscientious effort will be made to locate the parent or guardian before any action will be taken, but if it is not possible to locate the parent/guardian, the expense will be accepted by me. If the above named emergency contacts are not available, I authorize care by a physician on call at the hospital.

Parent: _____ Date: _____

Legal Guardian: _____ Date: _____

(You Must Provide a Copy of the Court Order)

Hearing Screening Permission

Pure tone hearing screening is mandated for grades K, 1, and 10. Students in all grades will be screened if they are **NEW to the school, on the annual hearing re-check list, or referred by a school staff member and/or by the parent/guardian. Please contact the school nurse if an ear-related medical issue arises.

PARENT Initial ONE:

_____ I give my permission for hearing screening for my child.

_____ I REFUSE to give permission for hearing screening for my child.