



Green Woods Charter School

THE WORLD IN OUR HANDS

HEALTH HISTORY FORM 2009-2010 SCHOOL YEAR

Student Name _____	Grade _____	Date _____
Date of Birth _____	Age _____	Date of Last Physical _____
Home Address _____		
Name of Parents/Guardians _____		
Home # _____	Work# _____	Cell# _____
Additional Emergency Contact: _____		
Relationship _____	Phone# _____	
Student's Physician _____	Phone# _____	
Date of last physical exam _____		
Health Insurance _____		
Policy # _____		
Student's Dentist _____	Phone# _____	
Date of last dental exam _____		
Student's Optometrist _____	Phone# _____	
Date of last eye exam _____		

Disease/Illness History		
An injury/fracture or illness since last physical? Explain _____	Yes	No
Surgery, hospitalizations or any other Emergency Room visits? Explain _____	Yes	No
A chronic or ongoing illness (such as diabetes or asthma)? Name of illness _____	Yes	No
An inhaler or other prescription medicine to control chronic illness? Name of medication _____	Yes	No

Asthma		
Asthma symptoms brought on by weather changes: humidity cold	Yes	No
Exercised induced asthma?	Yes	No
Upper Respiratory Infection induced asthma?	Yes	No
Seasonal environmental allergy induced asthma? Pollen?	Yes	No
Your child's best Peak Flow reading ** _____ **		
List Asthma Medications:		
Daily maintenance medications: _____		
Rescue Medications: _____		

Allergies		
Medication allergy?	Yes	No
Name of medication _____		
Describe reaction _____		
Food allergy?	Yes	No
Food/s allergic to: _____		
Describe reaction _____		
Latex allergy?	Yes	No
Describe reaction _____		
Bee sting/insect sting allergy?	Yes	No
Describe reaction _____		
Any other allergies?	Yes	No
Explain _____		

Seizures	Yes	No
Type of seizures _____		
Name of seizure medication _____		
Frequent nose bleeds?	Yes	No
Menstruation? Onset? _____	Yes	No
Cardiac/Heart Diagnosis? circle murmur? VSD? PDA?	Yes	No
Explain _____		
Anemia, blood disorders, sickle cell disease/trait?	Yes	No
Explain _____		
Lyme Disease? Date _____	Yes	No
Obesity? BMI above 85%	Yes	No
Healthy Body Plan: _____		
Please list any condition your child may have which might limit his/her activities at school. _____		
Vision Loss/Correction eyeglasses contacts	Yes	No
Hearing Loss hearing aides or implants	Yes	No

ADD/ADHD?	Yes	No
Name of medication _____		
Special Education Services? circle IEP? 504?	Yes	No
Psychological/Psychiatric (anxiety, depression, other)	Yes	No
Explain _____		
Name of medication for psychiatric disorder _____		
Have there been any changes in your family during the past year, such as:		
Separation, divorce or remarriage?	Yes	No
Death or serious illness	Yes	No
Any other situation that might affect your child?	Yes	No
PLEASE EXPLAIN ON NEXT PAGE...		

Explain (include relevant dates)

List **ALL** medications here:

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide dates and documentation from physician on immunizations received since our last school year.

Varicella (chickenpox)_____ **Td** (booster)_____ **HPV** (cervical cancer)_____

Menactra (meningococcal & meningitis)_____ **Influenza** (annual flu)_____

Permission To Receive Over The Counter Medication

The School Nurse has standing orders from GWCS physician to administer specific over the counter medication to your child. Your child must have had the medication in the past and will not be receiving it for the first time.

The school nurse has my permission to administer the following medication (check ALL that you give your permission for). Per our Health Room orders from our school physician no medication of any kind will be given to a student the first or last period of the school day.

____ **Tylenol (acetaminophen)** ____ **Advil, Motrin (ibuprofen)**
____ **Tums (antacids)** ____ **Caladryl (topical itch relief)**
____ **Benadryl (allergic reactions only)** ____ **Epi-Pens (acute allergic reaction!)**
____ **DO NOT give any medications without a phone call to me first**

Parent/Guardian Signature _____ **Date** _____

Consent For Medical Information

There may be occasions on which we need to contact your physician or dentist for health information.

Parent/Guardian Signature _____ **Date** _____