

Green Woods Charter School

Health History Form

2010-2011

Please do not leave any question blank

Student Name: _____	Grade _____
Age _____	Date of Birth _____
Name of Parent/Guardian _____	
Home phone # _____	cell# _____ best reached @ _____
Student's physician _____	Phone _____
Health Insurance carrier(required) _____	Group# _____
Student's dentist _____	last dental exam _____ Phone _____
Student's Optometrist _____	last eye exam _____

Health Information

Any injury/fracture or illness since last school year? Yes No

Explain _____

Surgery, hospitalizations or other Emergency Room visits? Yes No

Explain _____

A chronic or ongoing illness (ie. Diabetes or asthma)? Yes No

Name of illness _____

Inhaler or **prescription medication** to control chronic illness? Yes No

Name of **all** medications _____

Please list any **allergies** to food, medication, insects w/ Emergency Care Plan _____

Does your child require a Epi-pen* for allergic reaction? Yes No

Current Health Problems: (please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Dental problem | <input type="checkbox"/> Neurological problem |
| <input type="checkbox"/> Anxiety or depression | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Respiratory problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Restrictions in activity |
| <input type="checkbox"/> Athletic injury | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Behavioral or emotional | <input type="checkbox"/> Gastrointestinal problem | <input type="checkbox"/> Skin problem |
| <input type="checkbox"/> Bladder problem | <input type="checkbox"/> Hearing or vision | <input type="checkbox"/> Speech problem |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Lymes Disease | <input type="checkbox"/> Surgical history |
| <input type="checkbox"/> Cardiac disorder | <input type="checkbox"/> Migraines or headaches | <input type="checkbox"/> Tuberculosis exposure |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Musculoskeletal problem | <input type="checkbox"/> Obesity_BMI above 85% |

Please explain above _____

Does your child have a 504 ? IEP? Or receive Special Education Services? _____

The school nurse has my permission to administer the following medications to my child, as needed, during the school day:

Tylenol Advil Tums Benadryl(allergic reaction only) Caladryl
 Epi-Pen* (allergic reaction, emergency only)

Parental consent requested to contact your child's physician or dentist for health information if indicated

Parent/Guardian Signature: _____ Date _____