THE GREATER ALLEGHANY SCHOOL HEALTH PROJECT

2019 – 2020

Student Health History Form

(Please complete entire form, sign, and return to school as soon as possible.)

Name: (Last)_____ (First)_____ (MI) _____ **Sex**:☐ M or ☐F **Grade:** _____

Birthdate: ____/_____/____ **HR Teacher**: _____ **Address**: _____

Parent/Guardian* (Call 1st)**:_____Relationship to Student***_____
Home #_____ **Work #**_____ **Cell #**_____
Parent/Guardian* (Call 2nd)**:_____Relationship to Student***_____
Home #_____ **Work #**_____ **Cell #**_____

Emergency contact names/numbers if parent listed above cannot be reached:
1. **Name**: _____ **Relationship**_____ **Home#**_____**Work#** _____ **Cell #** _____

2. **Name**: _____ **Relationship**_____ **Home#**_____**Work#** _____ **Cell #** _____

Physician: _____ **Dentist:** _____

Your child has the following health insurance (Please mark all that apply):☐**Private** ☐**Medicaid** ☐**FAMIS** ☐**None**

Please mark all that apply to student:

Allergies / Hayfever (list below) ☐	Bleeding / Clotting Disorder ☐	Head Injury / Concussion ☐	Orthopedic / Bone ☐
Bee Sting / Insect Allergy (list below) ☐	Cerebral Palsy ☐	Headaches ☐	**Medication Allergies / Reaction (list below)** ☐
ADHD ☐	Chickenpox ☐	Hearing Loss ☐	Psychological / Psychiatric Treatment ☐
Anemia (include Sickle Cell) ☐	Cystic Fibrosis ☐	Heart Condition / Murmur ☐	Scoliosis ☐
Arthritis ☐	**Diabetes** ☐	Hypertension ☐	**Seizures** ☐
Asthma ☐	**Food Allergy (list below)** ☐	Lead Exposure ☐	Skin Disorders ☐
Bladder / Kidney Disease ☐	Gastro-intestinal ☐	Mononucleosis ☐	Vision Loss / Correction ☐

Please give details / dates of all conditions checked above and other health conditions not listed. _____

_____

_____

Is your child taking medication (Prescription or Over-the-Counter)? Yes _____No_____ **If Yes, complete the following**:

Name:_____ Dosage:_____ Reason for use:_____

Name:_____ Dosage:_____ Reason for use:_____
(If more than two, please list below)

*I give permission for my child to have the following medications if the nurse/school personnel feel it is necessary. I understand and accept that the Alleghany County/Covington School Boards, its employees, agents or designees are not responsible for any effects of the medication administered.

Tylenol:☐**Yes** ☐**No** **Benadryl:**☐**Yes** ☐**No** **Cough Drops:**☐**Yes**☐ **No**

*I give permission for the nurse to share information with administration/faculty regarding health problems that may require emergency intervention.
☐**Yes** ☐ **No**

*I give permission for my child to be transported to the hospital in the event of an emergency. ☐**Yes** ☐ **No**

*I authorize my child's health care provider and designated provider of health care/school official to discuss my child's health concerns and/or exchange information. You may withdraw your authorization at any time by contacting your child's school. ☐**Yes** ☐ **No**

Please see school handbook in regard to medication at school and on the bus.

Parent/Guardian Signature _____ **Date**_____ rev 05/19