GMA+ General McLane School District

www.generalmclane.org

HEALTH HISTORY

STUDENT DEMOGRAPHIC INFORMATION:					
School:		Grade:		Date:	
Child's Full Name:	*(First)*	*(Middle)*	*(Last/Suffix)*		
Sex: ☐ Male ☐ Female		Date of Birth:		Phone:	
Address:	*(Street)*	*(City)*	*(Zip Code)*		
School Last Attended:					
School Address:	*(Street)*	*(City)*	*(State)*	*(Zip Code)*	
School Phone:		Date of Last Attendance:			

PHYSICIAN INFORMATION:		
Family Physician:		Phone:
Is child presently under medical treatment for medical/emotional reasons?	☐ Yes ☐ No	
If yes, reason:		
If yes, give name of physician:		Phone:
I give permission for the school to dispense:	Acetaminophen or Ibuprofen ☐ Yes ☐ No	Antacid **:** ☐ Yes ☐ No
EMERGENCIES/ALLERGIES:		
Any medication needed for emergencies/allergies must be provided by the parent, including Bendaryl and EpiPens for bee sting/allergic reactions.		
In the event I cannot be contacted using the listed information, I granted permission to the receiving health care facility to administer appropriate care to my child: ☐ Yes ☐ No		
Preferred Hospital:		

Please note: If your child has any health condition that requires care or medication during the school day, please contact the school nurse to develop a plan for care. Thank you!

Parent/Guardian Signature ____________________ Date ____________________

Please complete both sides of the form. Thank you!

Revised 3/2016

HEALTH HISTORY (Please answer all questions):

1. Is your child currently taking medication? ☐ Yes ☐ No Inhaler? ☐ Yes ☐ No

   Will the child need medication during school hours? ☐ Yes ☐ No

   *Any medication to be taken at school must have a "**Medication Release Form**" completed and on file in the nurse's office.*

   List all medications taken, dosage, and doctor prescribing: ______________________

2. Does your child have diabetes? ☐ Yes ☐ No

3. Does your child have any allergies? ☐ Yes ☐ No EpiPen? ☐ Yes ☐ No

   ☐ Bee Sting ☐ Dust ☐ Plants ☐ Animals ☐ Foods

   ☐ Drugs *Please list:* ______________ ☐ Other ______________

   Explain reaction: ______________________

4. Has your child ever had convulsions or seizures? ☐ Yes ☐ No

   If yes, when was last seizure? ______________ Currently taking seizure medication? ☐ Yes ☐ No

5. Has your child ever had any of the following diseases? Please give month/year. ☐ Not applicable

   ☐ Asthma ______ ☐ Heart Condition ______ ☐ Tuberculosis ______

   ☐ Chicken Pox ______ ☐ Mononucleosis ______ ☐ Scoliosis ______

6. Is your child frequently troubled by any of the following? ☐ Not applicable

   ☐ Bladder/Bowel Problems ☐ Emotional Problems ☐ Over 4 Colds Per Year

   ☐ Earaches ☐ Headaches ☐ Painful Joints

   ☐ Eczema ☐ Nosebleeds

   ☐ Other - Please explain: ______________________

7. Does your child require a special diet? ☐ Yes ☐ No

   If yes, note restrictions: ______________________

8. Does your child experience any difficulty with: ☐ Not applicable

   ☐ Speech ☐ Hearing ☐ Vision

   Please explain: ______________________

9. Has your child had any serious injuries, accidents or operations? ☐ Yes ☐ No

   If yes, list and give dates: ______________________

10. Does your child have any physical disability? ☐ Yes ☐ No

    If yes, please describe: ______________________

Additional Comments: