South Spencer School Corporation
Student Health History

Name of child: ___________________________ Birth date: __________ Grade:__________

Please complete the following questions to the best of your knowledge. The information gathered here will help us in caring for your child throughout the school year.

If you answer "yes" to any of the questions, please explain. If you answer yes to a question with an ** please ask the office for the appropriate health plan.

Does your child have a medical history of or problems with…

Has your child had chicken pox? Yes – mo/yr__________ No

	Circle Yes or No	Explain if answered yes
**Allergies (food, bees, medicine)	Yes No	
**Asthma (medication)	Yes No	
Behavioral disorder ex. ADD, ADHD (diagnosed by a doctor)	Yes No	
**Severe reaction to bee stings (if so describe action that needs to be taken if this were to happen)	Yes No	
Eye problems (glasses/contacts)	Yes No	
Ear infections/ Hearing problems (tubes in ears?)	Yes No	
Kidney/Bladder problems	Yes No	
**Epilepsy/history of seizures (medication, last seizure)	Yes No	
**Orthopedic/ Bones (broken bones, casts, braces)	Yes No	
**Diabetes (diet/medication)	Yes No	
Operations (appendectomy, tonsillectomy, etc)	Yes No	
Special Needs (Learning, speech, etc.)	Yes No	

Is your child taking any medications? Yes No

	Medication	Dosage	Times Taken	Reason Taken
1.	________________________	________	____________	_________________________
2.	________________________	________	____________	_________________________

Many qualified school employees work with your child. We feel it is very important that all school employees, including bus drivers, cooks, substitute teachers etc., know when students have special health concerns that need immediate attention. Please assist us in meeting your child's needs by signing below.

In order that my child may receive the best possible health care, I give permission for the information on this form to be shared with necessary school employees. I also give permission for the nurse to contact my child's physician if questions arise regarding care while in school.

Parent Signature: ____________________________________ Date: ____________________