Date Sent:_____ **UNIONTOWN AREA SCHOOL DISTRICT** **HF-33**

Date Rec'd:_____ **STUDENT HEALTH HISTORY**

STUDENT'S NAME:_____ **M/F:**_____ **GRADE:**_____ **D.O.B.**____/___/_____

MOTHER'S NAME:_____ **CELL #:**_____**HOME #:**_____

FATHER'S NAME:_____ **CELL #:**_____**HOME #:**_____

Has Your Child Had Any of the Following?

1. Allergies	**Yes**	**No**	**14. Blood Disorders**	**Yes**	**No**
Environmental/Seasonal			Explain:		
Food			**15. Head Injuries**		
Medical			Explain:		
Epi-pen			Date:		
Explain:			**16. Serious Accidents**		
2. Asthma			Explain:		
Date of last attack:			Date:		
Type of inhaler:			**17. Operations**		
Triggers:			Explain:		
3. Chickenpox			Date:		
Age of child: Month & Year			**18. Recurring Illness**		
4. Convulsions/Seizures			Explain:		
Explain:			Date:		
Date of last Seizure:			**19. Physical Handicaps**		
Triggers:			Explain:		
Medication:			**20. Vision Problems**		
Doctor:			Wears Glasses/Contacts		
5. Diabetes			Other:		
Type:			**21. Speech Problem**		
6. Fainting Spells			**22. Physical Limitations**		
Causes:			Explain:		
Last Episode:			**23. Attention Deficit**		
7. Heart Disease			Date Diagnosed:		
High Blood Pressure			Diagnosed By:		
Murmur			Medications:		
Open Heart Surgery			**24. Hyperactive Disorder**		
Other:			**25. Autism**		
8. Hearing Problems			**26. Emotional Disorder**		
9. Chronic Ear Infections			Explain:		
Tubes			**27. Behavior Disorder**		
Hearing Loss			Explain:		
Explain:			**28. Chronic Fatigue Syndrome**		
10. Skin Disorders			**29. Narcolepsy**		
Explain:			**30. Depression**		
11. Spina Bifida			Doctor:		
12. Scoliosis/Curvature of the spine			**31. Has your child ever been stung by a bee?**		
13. Urinary Tract Infections			**32. Has your child ever had a reaction to a bee sting? Please explain reaction?**		

List any medical care (past or present) your child may have received: _____

_____

_____

OVER

UNIONTOWN AREA SCHOOL DISTRICT

STUDENT HEALTH HISTORY

STUDENT'S NAME_____ **GRADE**_____ **D.O.B.**_____/_____/_____

Please provide details for any "yes" answers on Page 1 (front page) of this form:

_____

_____

_____

_____

Is your child presently taking any medication(s)? **YES**_____ **NO**_____

NAME OF MEDICATION(S):_____ NAME OF MEDICATION(S):_____

DOSAGE:_____ DOSAGE:_____

TIME(S) ADMINISTERED:_____ TIME(S) ADMINISTERED:_____

REASON FOR UASGE:_____ REASON FOR USAGE:_____

NAME OF MEDICATION(S):_____ NAME OF MEDICATION(S):_____

DOSAGE:_____ DOSAGE:_____

TIME(S) ADMINISTERED:_____ TIME(S) ADMINISTERED:_____

REASON FOR UASGE:_____ REASON FOR USAGE:_____

Does your child have any additional health needs/problems or concerns the school should know about?

_____

_____

Doctor's Name:_____ Phone Number:_____

Dentist's Name:_____ Phone Number:_____

If the student moved during the school year, list the previous school attended:_____

By signing below, I give my permission for the School Nurse to share health information with the appropriate staff for the health and safety of my child, i.e. transportation, cafeteria, custodial staff, etc.

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL OF ANY CHANGES TO THIS FORM

I authorize the school to give simple first aid, if necessary, during the school day. In case of serious accident or illness, I request the school to contact me. If unable to reach me, the school may make whatever arrangements seem necessary. *Information on this card will be shared on a need to know basis. ***(PARENT ASSUMES COMPLETE RESPONSIBILITY IF CONSENT IS NOT GIVEN.)**

_____ _____ _____

Parent's Name (Please Print) **Parent's Signature** **Date**

Revised 2-18-16