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?

	Yes	No		Yes	No
1. Allergies			**15. Blood Disorders**		
Environmental			Explain:		
Seasonal			**16. Head Injuries**		
Food			Explain:		
Medical			Date:		
Epi-pen			**17. Serious Accidents**		
Explain:			Explain:		
2. Asthma			Date:		
Date of last attack:			**18. Operations**		
Type of inhaler:			Explain:		
Triggers:			Date:		
3. Chickenpox			**19. Recurring Illness**		
Age of child: Month & Year			Explain:		
4. Convulsions/Seizures			Date:		
Explain:			**20. Physical Handicaps**		
Date of last Seizure:			Explain:		
Triggers:			**21. Vision Problems**		
Medication:			Wears Glasses/Contacts		
Doctor:			Other:		
5. Diabetes			**22. Speech Problem**		
Type:			**23. Physical Limitations**		
6. Fainting Spells			Explain:		
Causes:			**24. Attention Deficit**		
Last Episode:			Date Diagnosed:		
7. Gastrointestinal			Diagnosed By:		
Type:			Medications:		
8. Heart Disease			**25. Hyperactive Disorder**		
High Blood Pressure			**26. Autism**		
Murmur			**27. Emotional Disorder**		
Open Heart Surgery			Explain:		
Other:			**28. Behavior Disorder**		
9. Hearing Problems			Explain:		
10. Chronic Ear Infections			**29. Chronic Fatigue Syndrome**		
Tubes			**30. Narcolepsy**		
Hearing Loss			**31. Depression**		
Explain:			Doctor:		
11. Skin Disorders			**32. Has your child ever been stung by a bee?**		
Explain:			**33. Has your child ever had a reaction to a bee sting? Please explain reaction?**		
12. Spina Bifida					
13. Scoliosis/Curvature of the spine					
14. Urinary Tract Infections					

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

_____

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 USAGE:_____ REASON FOR USAGE:_____

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

DOSAGE:_____ DOSAGE:_____

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

REASON FOR USAGE:_____ 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**