USD 396 – DOUGLASS PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

Student's Name_____ Grade_____DOB_____
Address: _____

Screenings:

Vision, Hearing and Dental Screenings are done yearly, as mandated by the state. Scoliosis screens are done on 5th and 7th grade girls and 8th grade boys. **If you do not wish to have your child screened for any reason, list the screenings you do *NOT* want your child to participate in and sign your name here.**_____

Medical History:

1. Does your child have any **life threatening** allergies? __Yes __No, If you answered yes, Please List:_____ Do they have an epi-pen? ___
2. Is your child allergic to **Latex**? Reaction? _____
3. Has your child ever been **diagnosed by a physician** with a food allergy? __Yes __No, if you answered yes please list:_____
   If your child has a food allergy and needs a substituted item for lunch (elementary only) a disability form must be filled out yearly for the state.
4. Has your child ever had a serious head injury? __Yes __No, if you answered yes, please describe:_____
5. Is your child on any medication? __Yes __No, if you answered yes, please list:_____
6. If your child will need to take any medication at school, see the nurse for instructions on what to do. **For each medication the child takes at school, a medicine permission form must be on file in the nurse's office. This form must be signed by the parents for over the counter medication and by the parents and the prescribing physician for prescription medications. NO EXCEPTIONS!**
7. Has your child ever been diagnosed with any of the following health problems? Circle all that apply.

ADD/ADHD	Autism	Asthma	Hypertension
Diabetes	Blood Disorders	Depression	Cerebral Palsy
Hypoglycemia	Heart Disease	Headaches/Migraines	
Scoliosis	Seizures	Stomach Problems	

Any issue, not listed here:_____
Hearing Problems Please Explain: _____

We routinely use ***triple antibiotic cream*** for minor cuts, ***Caladryl or hydro-cortisone creams*** for minor rashes, bug bites or poison ivy and ***cough drops or sore throat breezers*** for complaints of a cough or sore throat. If you do **NOT** want any of these used on your child, ***cross out the ones you do not want used.***

I authorize the use of the above over-the-counter medications for my child in the event of the conditions listed after the medication. I certify that my child has received the above medications before with no adverse effects and/or reactions. I agree not to hold USD 396 or its representatives responsible for any possible adverse reactions as a result of application or consumption of the above listed items. I understand it is my responsibility to notify the school nurse of any changes in health status or medications.

Parent/guardian signature:_____Date:_____

AUTHORIZATION FOR RELEASE OF INFORMATION - For WebIZ - Immunizations

I hereby authorize USD 396 to release immunization information in their possession relating to the above named student to Kansas Immunization Registry. Immunization information will be used for the purpose of assessment and reporting to prevent disease.

I affirm that I am authorized to consent to release medical information on behalf of the named student. I understand that this authorization is effective for 1 year from the date it is signed and that I may revoke this authorization in writing at any time.

Parent/Guardian Signature: _____ Date: _____

Relationship_____