School Year 2019-20

Elkins Primary School
Student Health History

Student Name: _____ Gender: M F

Current Grade: K 1st 2nd Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Primary Email: _____ Secondary Email: _____

Medically Diagnosed Conditions	Current	Past (year)	Never	Medically Diagnosed Conditions	Current	Past (year)	Never
*ADD/ADHD				Worry, Anxiety/Depression			
*Asthma				Seasonal Allergies			
Balance issues; leg braces, wheelchair, etc.				*Seizures/Convulsions			
Bladder/Bowel Problem				*Severe Allergies (requires Epi-Pen)			
Bleeding Problem				Severe behavioral issues			
Muscle Problems				Severe or Chronic Abdominal Pain			
Cerebral Palsy				Speech Problem			
Cystic Fibrosis				Heart Condition/Heart Surgeries			
*Diabetes				Tumor, Growth or Cancer			
Head or Spinal Injury/Concussion				Vision Problems/Wears Glasses or Contacts			

Asthma, Diabetes, Anaphylaxis Allergy or Seizure history requires a new Health Plan yearly, as well as any required medications to treat these conditions such as an inhaler, Benadryl and/or Epi-Pen. See school nurse.

Explain health conditions or concerns:

List all prescription and over-the-counter medication you child takes regularly/daily:

Will your child take prescription medication at school? Yes No
Name of Medication/Dose/Time of day to be given:

Student's Primary Care Physician _____ Phone: _____

By signing below, I give permission for any and all medical information to be shared with all school personnel that may interact with my child.

Parent/Guardian Signature: _____ Date: _____