School Year_____

Grade/Teacher_____

Eufaula Public Schools
Health History

Student's Name _____ Date of Birth_____ Sex___ Race_____

SSN _____ Medicaid/SoonerCare # _____

Student's Address _____
Street/Apt. # City/State Zip Code

Parent/Guardian _____
Name Home # Work # Cell #_

Parent/Guardian _____
Name Home # Work # Cell #

Contact Person _____
Name Home # Work # Cell #

Student's Doctor _____ Phone # _____ Last Seen _____
Dentist _____ Phone # _____ Last Seen _____
Specialist _____ Phone # _____ Last Seen _____

Health History: Please check any condition below that the student has had, past or present. Please explain condition below.

__Asthma
__ADD/ADHD
__Autism
__Behavior/emotional concerns
__Birth/congenital malformations
__Bone/muscle/joint problems
__Blood problems
__Bowel/bladder/kidney problems
__Cancer
__Cystic fibrosis
__Diabetes
__Ear/hearing problems
__Headaches
__Heart problems
__Hospitalizations
__Lead poisoning
__Seizure disorder
__Skin conditions
__Surgeries
__Vision problems
__Other __None

Allergies: __Life Threatening Food _____ Insect _____
__Seasonal Medication:_____ Other: _____
Are any allergies life threatening?_____

Will the student need to take any medication at school?____ Students requiring medication (prescription or nonprescription) at school MUST have written parent consent. Prescription medications also must have a written physician order. Please contact the school nurse or go on-line to www.eufaul.k12.ok.us for consent forms and guidelines for medications at school.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Parent/Guardian Signature_____ Date_____

Revised08/2010