South Central Schools Unit #401 Health History Information

Student's Name _____DOB_____ Grade_____

Please answer the following yes/no questions. If you answer yes explain in area provided.

ADD/ADHD Medications	YES NO	Comments:	Diabetes Insulin	YES NO	Comments:	Female/Reproductive Problems Pain PMS Medications	YES NO	Comments:
Allergies Environmental Food Insect Medication	YES NO		Dietary needs Dietary restrictions **FOOD ALLERGIES**	YES NO		Heart Problems Heart Murmur High Blood Pressure	YES NO	
Asthma Wheeze Cough Exercise	YES NO		Ear/ Hearing Problems Tubes Hearing Aides	YES NO		Mental Health Concern Depression Bipolar	YES NO	
Birth Defect Developmental Delay; Neurological Disorder	YES NO		Eye problems Vision problems Glasses	YES NO		Seizure? What are they like? How long do they last?	YES NO	
Bone/Joint Problems	YES NO		Head Injury Concussion Skull Fracture	YES NO		Bowel/ Urinary Problems? Wets Clothing?	Yes NO	
Blood Disorder	YES NO		Headaches Migraines Medications	YES NO		Serious illness/ Injury?	YES NO	

LIST ALL MEDICATIONS: (if we would ever need an Ambulance, they will need to know all of student's medication)

DOCTOR:_____Phone#:_____

DENTIST:_____Phone#: _____

I, Parent/Guardian of above named student, give consent to the South Central School District to provide emergency care to my child in my absence. I understand if an ambulance is medically necessary, I accept financial responsibly.

I hereby authorize the South Central Schools to disclose my child's health information to teachers, substitute teachers, and cafeteria staff at the school or at school events and field trips to the extent necessary for the protection of my child.

I hereby authorize South Central School's Nurse or Principal to contact the above listed physicians regarding my child for the purpose of providing information or treatment medically necessary for my child's well being.

Parent/Guardian Signature:_____ Date:_____