USD 403 Otis-Bison Student Health History *2017-2018*

This form must be completed every school year so that current health information is available for the school nurse. Contact the nurse with questions.

Student Name______________________________**Date of Birth**__________**Grade**_____

Does your child have an IEP? Yes__No__Explain____

Date of Last: Dental Exam_____Dentist________________________Eye Exam_____Eye Doctor________________________

Name of Health Care Provider____________________________City______________Date Last Physical Exam________________

Type of Health Insurance: __Private__Health Wave__Medicaid__Social Security__Unknown__No Insurance

DOES YOUR CHILD HAVE ANY SPECIAL NEEDS IN THESE AREAS?

(Please answer yes or no for each question)

	YES	NO	
ACTIVITY RESTRICTIONS Physicians Order Required	___	___	Explain________________
ALLERGIES: None__Food__Insects__Seasonal __Medication______________	___	___	List allergens/restrictions ________________
ASTHMA / BREATHING	___	___	Inhaler (name)________________
ARTHRITIS	___	___	Explain________________
BEHAVIOR / LEARNING	___	___	Explain________________
BLOOD DISORDER	___	___	Explain________________
BIRTH DEFECTS ~ List__________________	___	___	Explain________________
BOWEL / BLADDER CONCERNS	___	___	
Constipation__Infections__Needs Restroom Pass__Needs Assistance__ List:________________			
CANCER	___	___	Explain________________
DIABETES / HYPOGLYCEMIA	___	___	Insulin (name)________________
Physician Order required for diabetic management / medications			Self Manages__Needs Assistance__
DEPRESSION / MENTAL HEALTH CONCERNS	___	___	Medication___Therapist___Other____________
EARS / HEARING	___	___	Infections___Tubes___Aides___Hearing Loss___
EYES / VISION	___	___	Wears glasses___Contacts___Other____________
FRACTUES / BROKEN BONES	___	___	Explain________________
FREQUENT INFECTIONS	___	___	Explain________________
HEAD ACHES	___	___	Explain________________
HEAD INJURY	___	___	When occurred__________Restrictions________
HEART CONDITION / MURMUR	___	___	Pacemaker___Restrictions____________
IMMUNE SYSTEM DISORDER	___	___	Explain________________
JOINT / SKELETAL / BONE PROBLEMS	___	___	Explain________________
MEDICINE ***(Physician Order required each year)***	___	___	
Taken at: School (Circle) Daily / Time________________	As Needed__At Home (note time)________________		
List:________________________________			
MENSTRUAL CYCLE	___	___	Explain________________
MUSCLE PROBLEMS	___	___	Explain________________
NURSING PROCEDURE	***Physician Order required for procedure done by nurse***		
MOBILITY AIDES / ASSISTIVE DEVICES	___	___	Brace (s)____Wheelchair___Other____________
SEIZURES / NEUROLOGICAL PROBLEMS	___	___	Explain________________
SERIOUS ACCIDENTS	___	___	Explain________________
SKIN CONDITION	___	___	Explain________________
SPECIAL DIET / RESTRICTIONS ***(Physician Order Required)***	___	___	Explain________________
SUPPLEMENT USE	___	___	Explain________________
SURGERIES	___	___	Explain________________

****Only check yes for medical condition that your child has been diagnosed with by physician***

***Please read and sign:** I understand that health history information is kept by the school nurse and that she may determine when appropriate portions of this information may be shared with other school district staff members who are providing a service to my son / daughter. I give my consent for my child's immunization information to be shared with the Kansas Immunization Program for the purpose of assessment and reporting*

Parent / Guardian Signature____***Date***______________