

York Public Schools Health History

Student's name _____

Sex

☐ Male

☐ Female

Date of birth

/ /

Student Health Conditions

☐ **YES**, my child receives regular medical/health care for the following conditions:

☐ **NO** medical conditions

☐ Allergies

☐ Diabetes

☐ Seizure disorder

☐ Asthma

☐ Depression

☐ Sickle cell anemia

☐ ADD/ADHD

☐ Multiple Ear Infections

☐ Skin conditions

☐ Autism

☐ Emotional concerns

☐ Speech problems

☐ Behavior concerns

☐ Headaches

☐ Traumatic brain injury

☐ Birth/congenital malformations

☐ Heart problems

☐ Uses inhaler/nebulizer

☐ Bone/muscle/joint problems

☐ Hemophilia

☐ Vision problems (glasses, contacts)

☐ Blood problems

☐ Juvenile arthritis

☐ Other _____

☐ Bowel/bladder problems

☐ Nose Bleeds

☐ Other _____

☐ Cancer

☐ Migraines

☐ Other _____

☐ Cystic fibrosis

☐ Neuromuscular disorder

☐ Other _____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have. Please list if your child carries/uses an epipen

Allergy type

Reaction

School restrictions or recommended actions

☐ Bee/Insect

☐ Food

☐ Medication

☐ Other

Please list any prescription and over the counter medication that your child takes on a regular basis.

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes

☐ No

If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes

☐ No

If YES, please explain.

Child's health insurance: _____None _____Medicaid/Kid's Connection _____Private/Commercial/Employer

Date of last dental exam _____ Date of last eye exam _____

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form Completed by _____ Relationship to Student _____ Date _____

Dear Parent/Guardian:

On the bottom of this letter is a Medication Permit Form to be signed by the parent or guardian and returned to the school if you would like your student to be able to receive Acetaminophen, without you being contacted, for minor health concerns. By signing and returning this form, we will be able to administer Acetaminophen pain reliever to your student for an occasional headache or other mild discomfort. A current form is required for each new school year. Without this form, the school cannot give your student acetaminophen without contacting you for permission. **If this permission form is completed, the school may also provide as needed: generic antibiotic ointment, generic chewable antacid tabs, and generic anti-itch lotion. Please notify the nurse should you not want these medications to be given to your student.**

All efforts should be made for students to take routine medication at home. If your student needs to take prescription or non-prescription medication at school, this medication must be brought to the office by an adult. This medication must be in its original packaging and accompanied by a note from parent/guardian as to how/when it should be administered.

A health history questionnaire is located on the reverse side of this form. **Please complete the health history portion and return to the school health office even if you choose to not to complete the Acetaminophen permission form.**

If your student has a chronic health condition such as Asthma, Life-threatening Allergy, Seizures, Diabetes or any other health concern that may impact your student's school day, please contact the nurse by email or phone during the weeks prior to the first day of school so that medical information may be reviewed. This information will assist us in coordinating care for your student during the time that he/she is at school.

Please return this form to the front office at your child's school. If you have any questions, please contact Sue Arnold, RN or Atley Henderson, RN at 402-362-6655

ACETAMINOPHEN (TYLENOL) PERMISSION FORM

I give permission to York Public Schools to administer generic acetaminophen (Tylenol) to my child _____ as needed for occasional discomfort, fever or headache for this school year.

Parent / Guardian

Date