Lawrence Public Schools

PLEASE RETURN TO THE SCHOOL NURSE

HEALTH HISTORY FORM FOR _____ SCHOOL YEAR

STUDENT INFORMATION

Name of Student _____ Grade _____

Home Address _____ Home Phone _____

Date of Birth _____ Age _____ Sex ☐ F ☐ M School last attended _____

Mother/Guardian's Name _____ Wk # _____

Father/Guardian's Name _____ Wk # _____

Email address: _____ _____ _____

Cell phone: Mother _____ Cell Phone: Father _____

Student lives with __ Both Parents___Mother ___Father ___ Guardian

Physician _____ Phone _____ Hospital _____

Dentist _____ Phone _____

EMERGENCY CONTACTS (in cases when a Parent/Guardian cannot be reached)

1. Name _____ Hm/Cell # _____
2. Name _____ Hm/Cell # _____

HEALTH CONDITIONS (check those that apply)

☐ ADD / ADHD	☐ Eating Disorder
☐ Allergies (Life Threatening)	☐ Endocrine Disease
☐ Allergies	☐ G.I. Disorder (Stomach / Intestinal)
☐ Arthritis / Connective Tissue	☐ Genetic Disorder
☐ Asthma / Reactive Airway	☐ Headaches Type:
☐ Behavioral / Emotional / Psychological	☐ Hearing Impaired Hearing Aid __Yes __No
☐ Blood Disorder	☐ High Blood Pressure
☐ Brain / CNS Disorder	☐ Musculoskeletal Disorders
☐ Cancer	☐ Prosthesis
☐ Cardiovascular (Heart / Blood Disease)	☐ Seizure Disorder
☐ Cerebral Palsy	☐ Skin Disease
☐ Chicken Pox **Date:**	☐ Spina Bifida
☐ Cystic Fibrosis	☐ Urinary / Kidney Disease
☐ Dental	☐ Visually Impaired Glasses ___Yes ___No
☐ Developmental Delay	
☐ Diabetes	
☐ Other (Please List)	

Please fully explain any answers checked above (include severity and symptoms of any allergies)

_____

_____

Please list any medication the student takes on a regular basis_____

_____

Please list any other factors that the school nurse, counselor or your child's teacher(s) should know of which might affect the student's school experience_____

_____ 504 Plan on file? ☐ YES ☐ NO

Statement of Consent: This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health of the student. In order to better serve the health needs of my child, I hereby give permission for the transfer of health information to school and other appropriate health professionals, including immunizations status to state and local authorities as requested. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Parent/Guardian Signature: Date: