

MONTROSE & OLATHE SCHOOLS

Health History 2020-21

MUST BE COMPLETED BY PARENT/GUARDIAN EACH SCHOOL YEAR

Student: _____

Legal Last Name _____

Legal First Name _____

Date of Birth _____

Gender: Male Female

School: _____ **Grade:** _____

Physician

Physician Phone

Specialist

Specialist Phone

Student Health Conditions

Please fill in the information below if your child has been diagnosed and treated for any of the following conditions:

<input type="checkbox"/> YES, my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> NO Medical Conditions
<input type="checkbox"/> Allergies: Please list triggers and symptoms: _____		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cerebral Palsy/Neuromuscular Disorder	<input type="checkbox"/> Seizure Disorder Date of last seizure: _____
<input type="checkbox"/> ADD / <input type="checkbox"/> ADHD	<input type="checkbox"/> Diabetes - Type: _____	<input type="checkbox"/> Skin Condition(s)
<input type="checkbox"/> Autism: level of functioning _____	<input type="checkbox"/> Depression/Anxiety/Bi-Polar	<input type="checkbox"/> Traumatic Brain Injury/Concussion/Head Trauma
<input type="checkbox"/> Behavior Concerns	<input type="checkbox"/> Other Mental Health Concerns	<input type="checkbox"/> Vision Problems: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
<input type="checkbox"/> Birth/Congenital Malformations	<input type="checkbox"/> Headaches	<input type="checkbox"/> Ear Problem/Hearing Difficulty: <input type="checkbox"/> Hearing Aid(s)
<input type="checkbox"/> Bone/Muscle/Joint Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Assistive Devices: <input type="checkbox"/> Walker <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Leg Brace(s)
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Juvenile Arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/Bladder Problems	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer/Leukemia		

If any of the above conditions need attention at school, please provide further details: _____

Please list any medications taken at home:

Medication	Dosage	Frequency	Reason for taking medication

Please list any medications to be taken at school:

Medication	Dosage	Frequency	Reason for taking medication

*****Medications given at school MUST be accompanied by a signed physician order, signed parental permission, and MUST be in the original labeled container (Forms are available in the school Health Office).*****

The above information is considered confidential and is shared on a "need to know" basis between our Registered Nurses (District / School Nurses) and School Staff who will be in contact with and responsible for your child during the school day.

The Health offices at Montrose and Olathe Schools are staffed by Health Technicians who are under the supervision of our Registered Nurses and provide basic first aid to students as necessary.

Parent/Guardian Signature _____

Date _____