Finneytown Local School District

STUDENT HEALTH HISTORY UPDATE

Student _____ Grade_____ Today's Date_____

Please complete this form in its entirety and submit to the school prior to the start of the school year. Having an updated health history form allows us to provide better care and understanding should the need arise. Any pertinent information will be shared with school personnel on an as-needed basis. **Check all conditions that your child has.**

- ❑ **ADD / ADHD**
- ❑ **ALLERGIES** or reactions to: (please explain trigger and type of reaction (rash, throat swelling, etc.))
  Food(s): _____
  _____
  Medication(s): _____
  _____
  Plan/ Animal/ Environmental: _____
  _____
- ❑ **ASTHMA** (Identify Triggers)
  _____
  _____
  Has your child ever needed emergency treatment for asthma?
  ____YES _____NO
- ❑ **BLADDER PROBLEMS** (please explain) _____
  _____
  _____
- ❑ **BOWEL PROBLEMS** (please explain)
  _____
  _____
  _____
- ❑ **CYSTIC FIBROSIS**
- ❑ **DIABETES** Age of diagnosis _____
- ❑ **EAR INFECTIONS** (frequent after 3 yo)
  Approximate age or date of last infection
  _____
  Currently under care of ENT?
  __ YES __NO
  Currently has PE tubes?
  ____ YES ____ NO
- ❑ **EATING DISORDER** (Please explain)
  _____
  _____
- ❑ **EMOTIONAL/ BEHAVIORAL CONCERNS** (Please explain) _____
  _____
  _____
- ❑ **EYE PROBLEMS** (Please explain) ____
  _____
  Glasses? ___ YES ____ NO
  Date of last eye exam _____
- ❑ **HEADACHES** (frequent)
  Migraines? ___ YES ____NO
- ❑ **HEART CONDITION** (please explain)
  _____
  _____
- ❑ **KIDNEY DISEASE** (please explain)
  _____
  _____

- ❑ **MENSTRUAL PROBLEMS** (please explain)
  _____
  _____
- ❑ **PHYSICAL DISABILITY** (please explain)
  _____
  _____
- ❑ **RECENT HOSPITALIZATION/ SURGERY/ SIGNIFICANT INJURY** (please explain) _____
  _____
  _____
- ❑ **SICKLE CELL DISEASE** (not trait)
  Date of last sickle cell crisis _____
- ❑ **SEIZURES/ EPILEPSY**
  Date of last episode _____
- ❑ **SPINAL CURVATURE** (scoliosis, etc.)
  Currently under the care of orthopaedic?
  ___ YES ___ NO
- ❑ **TICS/ NERVOUS TWITCHES** (please describe) _____
  _____
  _____

My child takes the following daily medications _____
_____
_____
_____

My child takes the following medications occasionally _____
_____
_____

Please identify any other health information not listed above that you believe school personnel need to be aware of

_____
_____

- ❑ **NONE OF THE ABOVE APPLIES TO MY CHILD. MY CHILD HAS NO KNOWN HEALTH CONCERNS OR CONSIDERATIONS.**

This information may be shared with school personnel if it is pertinent to health and safety, educational progress and/or behavioral management plan.

Parent/Guardian Signature_____ **Date** _____