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CONFIDENTIAL STUDENT HEALTH HISTORY UPDATE

Name ______ ☐M ☐F DOB: ____ ____ Grade ____ School Year ____________

Mother / Guardian _____ Work # _____ Home # ______________Cell # ____

Father / Guardian ______________________________ Work # _____ Home # ______________Cell# _____

Physician ___________________________________ Phone# _______________ _____

Complete the following checklist by indicating any of the following student conditions, past or present.

DATE	YES*	NO			DATE	YES*	NO	
	☐	☐	Hearing Problem			☐	☐	Allergies / Environmental
	☐	☐	Heart Defect or Disease			☐	☐	Allergies / Food
	☐	☐	Hepatitis or Liver Problem			☐	☐	Allergies / Insect Stings or Bees
	☐	☐	Hernia			☐	☐	Allergies / Latex
	☐	☐	Hypertension			☐	☐	Allergies / Medications
	☐	☐	Immune System Disorder			☐	☐	Allergies / Other
	☐	☐	Infectious Disease, Current			☐	☐	Asthma / Breathing Problem
	☐	☐	Infectious Disease, Inactive			☐	☐	Behavioral Problem
	☐	☐	Lead Poisoning			☐	☐	Bladder / Kidney Disorder
	☐	☐	Menstrual Problem			☐	☐	Bleeding / Clotting Disorder
	☐	☐	Mobility Limitation			☐	☐	Bone / Joint / Muscular Disorder
	☐	☐	Mononucleosis			☐	☐	Cancer
	☐	☐	Orthodontic Treatment			☐	☐	Convulsions / Epilepsy / Seizure
	☐	☐	Physical Education Restriction			☐	☐	Dental Problem
	☐	☐	Psychological / Emotional Problem			☐	☐	Developmental Problem
	☐	☐	Scoliosis			☐	☐	Dizziness or Fainting
	☐	☐	Skin Condition			☐	☐	Diabetes
	☐	☐	Soiling / Incontinence			☐	☐	Dietary Restriction
	☐	☐	Speech Disorder			☐	☐	Digestive / Bowel Problem
	☐	☐	Surgery or Hospitalization			☐	☐	Eating Disorder
	☐	☐	Tuberculosis			☐	☐	Endocrine Disorder
	☐	☐	Vision or Eye Disorder			☐	☐	Head or Spinal Injury
	☐	☐	Other: (explain below)			☐	☐	Headaches / Migraines

*Provide details for all items above marked ***YES*** : ____

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Does the student's health condition require medically necessary medications or specialized health care treatments in school? ▢ YES ▢ NO

Explain: ____

Does the student take any medications, homeopathic supplements, or nutritional & performance supplements? ▢ YES ▢ NO

Explain: ____

CONFIDENTIAL STUDENT HEALTH HISTORY UPDATE continued

Name ______________________________ ▢M ▢ F DOB: ____ _ Grade ____ School Year ____________

Specifically ***during or after exercise,*** has the student experienced any of the following? Check all that apply:

▢ Fainting / Passing-Out ▢ Heat Stroke ▢ *Severe* Lightheadedness / Dizziness ▢ Coughing / Wheezing ▢ Excessive Bruising

▢ *Extreme* Shortness of Breath ▢ Chest Pain ▢ Numbness / Tingling in ______________________________ ▢ NONE APPLY

Was a Medical Evaluation done as a result of any of the above symptoms during exercise? ▢ YES ▢ NO

Outcome: ____

▢ **YES** ▢ **NO** **CONSENT FOR TREATMENT:** I give my permission for qualified school personnel to provide routine health care and first aid to my child as may be necessary during school and after school activities. I assume full responsibility for providing the school with all necessary student over-the-counter or prescription medications as well as necessary medical treatment supplies and authorizations.

▢ **YES** ▢ **NO** **CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide have my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff, primary healthcare providers, and extended day, for use in meeting the educational and health needs of my student. This consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance audits by the Virginia Department of Health and the Virginia Department of Social Services for licensed program compliance, if applicable.

Parent / Guardian Signature____Date____________________

Parent / Guardian Signature____Date____________________