JEFF TECH
576 Vo Tech Road
Reynoldsville, PA 15851
(814) 653-8265
FAX (814) 653-8425

Student Health History Form 2020-2021

Dear Parent/Guardian,

To ensure proper medical treatment at school, we rely on you to keep the school informed of new developments regarding your child's health. Please take time to complete the front and back of this form and provide signatures where requested, so we have current health information in your child's file for this school year. Thank you!

Student's Name ________________________________Grade: ____ Shop: ___________

Does your child require treatment for any of the following conditions?

- **Asthma:** YES or NO
  - Inhaler: __________________________
- **Bee Stings:** YES or NO
  - Benadryl or Epi-Pen: _______________
- **Life Threatening Allergy:** YES or NO
  - What is your child allergic to: ____
  - What are the symptoms of a reaction: _________________________________
  - Treatment: ____
- **Milk Allergy:** YES or NO
- **Seizures:** YES or NO
  - Type: ___________________________________
  - Treatment: ______________________________
- **Cardiovascular Disease:** YES or NO
  - Diagnosis: _______________________________
- **Bleeding Disorder:** YES or NO
  - Diagnosis: ________________________________

Health Conditions (Check All That Apply)		Specify/Explain
	Arthritis/Joint Disorder	
	Bowel/Gastrointestinal Problem	
	Brain/CNS Disorder	
	Cancer	
	Infectious Disease (i.e. Chicken Pox, Measles)	
	Diabetes	
	Drug Allergies	
	Environmental/Seasonal Allergies	
	Genetic Disorder	

	Headaches/Migraines	
	Hearing Impairment: RIGHT/LEFT/BOTH	Hearing Aid?
	Heart Murmur	
	Kidney/Urinary Disorder	
	Mental Health Disorder (i.e. ADD/ADHD, Autism, Depression, Anorexia)	
	Orthopedic Disorder	
	Skin Disease	
	Visual Impairment: RIGHT/LEFT/BOTH	Glasses/Contacts?
	Other (Please specify)	

Medications:

Please list any medications the student takes on a regular basis:

____

Please list any immunizations received within the past year with dates:

____

Does your child need to take medications during the school day (i.e. Epi-pen, inhaler, daily medications)?

____

The school nurse, or other designee approved by the school administrator, has my permission to administer the following medications as prescribed by the school physician to my child:

(Please circle the dosage that you are giving consent for)

Ibuprofen (Motrin): 200 mg 400 mg   Acetaminophen (Tylenol): 325 mg 650 mg   Orajel

Antacid (Tums): 1 tablet 2 tablets   Benadryl: 25 mg 50 mg   Epi-Pen   Cough Drops

X____   _________________

Parent/Guardian Signature   Date

I authorize school personnel to obtain **emergency medical care** for my child in the event that I cannot be reached. If **transportation by ambulance** is required, this may be obtained.

X____   _________________

Parent/Guardian Signature   Date

For the health, safety and welfare of your child, appropriate information may need to be shared with your child's teachers and staff as needed. Do you agree to the sharing of this information?

_____YES ______NO

X____   _________________

Parent/Guardian Signature   Date

If you have any questions or concerns, please call the school nurse at 814-653-8265 ext. 168.

Donna Overman, RN, BSN, CSN