Riverton School - Health History Form - School Year 20____ - 20____

Dear Parent/Guardian:

We would like for your child to gain the most from his/her school experience. In order to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to the school nurse.

Pupil's Name: _____ Grade: _____ Sex: _____ Date of Birth: _____

Name of family doctor/medical home: _____ Phone: _____

When was your child's last physical examination? _____

Allergies (include allergies to food, medications, insect stings and nature of reactions). _____

_____

_____

Prescribed Epi-Pen: Yes_____ No _____

*List **ALL** current medications here:*

Medication Name	Dosage	Reason

Does your child have asthma? ____ If yes, circle: mild, moderate, severe, exercised-induced, or illness-induced.

Age of diagnoses: _____ Most recent asthma attack: _____

Serious accident or injury (e.g. head injury, fracture, stitches): _____

_____

Hospitalizations/operations since birth: _____

Chronic or recurring illness: _____

Does your child have any restrictions on his/her activities? _____

Are there any situations in the home which might affect your child's learning? _____

_____

Is there anything about your child's health that you think is important for us to know? _____

_____

Health Status (past or present problems and/or illnesses). If yes, please explain

_____ Diabetes
_____ Anemia
_____ Sickle cell
_____ Heart problems
_____ Chronic ear infections
_____ Hearing problem
_____ Vision problem
_____ Wears glasses/contacts
_____ Skin problem

_____ Frequent nosebleeds
_____ Frequent headaches
_____ Frequent stomachaches
_____ Urinary Problems
_____ Urinary tract infections
_____ Kidney problems
_____ Hepatitis
_____ Scoliosis
_____ Wheeze or cough

_____ Dizziness/Fainting
_____ Seizures
_____ Cystic Fibrosis
_____ Hemophilia
_____ Bowel Problems
_____ Impulsive behavior
_____ Nervous habits
_____ Other problems

_____

_____

"I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary."

Non-Prescription Pain Relievers

_____Yes _____No **I give permission** for my child to take an age/weight appropriate dose of Acetaminophen (**Tylenol**) for the following indications:

1. Headache
2. Pain associated with cuts, scrapes, sprains, strains
3. Throat pain
4. Fever
5. Dysmenorrhea (menstrual cramps)

Parent/Guardian Signature_____ Date _____