FABIUS-POMPEY ELEMENTARY SCHOOL

Health History Screening Form (Grades 1-5)

Student's Name____ Date of Birth____/____/_____

Student's Health Care Provider/Address ____

1. Has your child ever had any of the following?

_____heart disease _____serious injuries _____asthma _____ diabetes

_____head injuries _____ADHD _____anxiety _____ food allergies

_____epilepsy/seizures _____ear infections _____kidney disease _____ other

_____ enviromental allergies

2. Any surgeries? _______ Please list: ____

3. Ever been hospitalized? _____ For what reason? ______________________________________

4. Please list all medications your child presently takes and the conditions that they are prescribed:

____

____

5. Will your child need to take medication at school? ____ What? __________________________

For ____

6. Has your child had difficulty seeing? _____ Glasses? _______ Last eye exam? _____________

7. Has your child had difficulty hearing? ______ Tested? _____ Results? ____________________

8. Has your child ever seen a dentist? ______ Last exam? ________________________________

9. Does your child have any food allergies? ____ To what? _____________________ Medications prescribed? ______ What?_____________________________ Will they take them at school?_____

10. Does your child have a bee sting allergy? _____ Medications prescribed? _____ What? ______ Will they take at school? ________

10. Any other comments or concerns? ____

____

Any medications at school must be done so following the medication administration policy.

I understand that all information, reports and/or testing results will be treated confidentially.

____ ______________________

Parent/Guardian Signature Date