## Student Health History | 20-21 SY

Student Nam					Date of Birth:							
(Last)			_		rst)	(Middle)						
Grade: Gender: Student ID #: Homeroom Teacher:											-	
FWISD would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing												
this, it is necessary to have a current health history. Please contact the school nurse if you have any health related												
question(s). Parent/Guardia	n:											
Home Phone N	Work I				Phone 1	Number:			Cell Phone			
Primary Physician:			Physician				hone N	umber:		Date of	Last Exam	
Specialist:Specialist Phone Number:												
Allergies:												
List Food(s): List Medication	n(s): Type									_		
Life Threatening Yes No EpiPen Prescribed Yes No												
Please indicate with a check (V) if your child has experienced any of the following conditions:												
Conditions:	with a che	Past										
ADD/ADHD			Fresen	FI	Please Explain:							
Asthma				In	Inhaler Yes No Nebulizer Yes No							
Chicken Pox					Date of Disease:							
Depression				10.	DAIL OF PRINCIPLE							
Diabetes				Type 1								
Eczema				Ole a Charles								
Headaches				Type:								
Heart Condition				(-71:								
Nausea/Vomiting				+								
GI/Stomach												
Learning Problems												
Mood Disorder/Behavior												
Nosebleeds												
Other Condition(s)												
Seasonal Allergies												
Seizures/Convulsions				D	Date of Last Seizure:Type of Seizure:							
Sickle Cell Anemia				$\perp$								
Urinary/Bowel												
Please Circle			NESSA 3 2011		, ,							
Vision Problem:	Glasses	YES	NO NO		Currently wears Currently wears		YES	NO	Has worn in past	YES	NO	
	Contacts	YES					YES	NO	Has worn in past	YES	NO	
Hearing Loss:	Right Ear	YES	NO	)	Hearing	Aid	YES	NO	Frequent Ear Infections	YES	NO	
l training trains	Left Ear	YES	NO		Ear Tubes YI			NO	Please Explain:	1 2.15	110	
Is your chile	d currently	*	gany			List M	edicatio	on(s) and	l Reason:			
medication(s)?					NO			. ,				
Has he/she ever taken any other medications in						List Med	dication(s	s) and Reas	son:			
the past on a routine basis?				YES	<u> </u>							
Did your child experience any problems at b			it birth?	YES	ES NO Please Explain:							
Has your child ever been hospitalized for reason?				YES		Please F	Please Explain:					
Is there anything more about your child that you think is important for us to know				VES	YES NO Please Es		xplain:					
Would you like to discuss your child'					Please Explain:							
with a School Nu	rse?			YES		20000-000	1100					
Confidential Protected Health Information: This document contains or requests "protected health information" within the meaning of the Health												
Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law prohibits wrongful use, access or disclosure of protected health information other than as allowed under HIPPA. Wrongful access, use, or disclosure of this information may expose violators to civil and criminal liability under Federal law, as other civil remedies under state law.												
Parent/Guardian Signature: Date:												