**RSU 40 School Health Services**
**320 Manktown Road**
**Waldoboro, ME 04572**
**(207) 832-8109 Fax (207) 832-8256**

# Student Health History

Dear Parent or Guardian,

In order to update your child's confidential health record we ask that you complete the following questionnaire, and return this form to their school. Thank you,

Linda Jacoby, R.N. Sandra Lufkin, R. N. Sherri Vail, R.N.

Student Name _____ Mailing Address _____

Date of Birth _____ School/Grade/Teacher _____ Telephone _____

| Yes | No | | |
|---|---|---|---|
| | | **LIFE THREATENING ALLERGY** | Allergic to what?<br>My child will have an auto-injector at school: ____Yes ____No<br>Describe previous reactions and at what age: |
| | | **Non-life threatening allergy** | Allergic to what:<br>Describe previous reaction: |
| | | **Asthma** | My child will be using an inhaler at school: ____Yes ____No |
| | | **Diabetes (Circle one)**<br>**Type 1 Type 2** | Insulin Dependent? ____Yes ____No<br>If yes, please see the school nurse to develop a diabetic care plan for your child. |
| | | **Heart Condition** | List condition:<br>Any restrictions? ____Yes ____No<br>If yes, please describe:<br>List any medications: |
| | | **Seizures** | Describe seizures:<br>Date of last seizure:<br>How frequent are seizures? |
| | | **Concussion (diagnosed by healthcare provider)** | How many concussions?_____ Date of most recent concussion:_____ |
| | | **Accident (broken bone, major trauma, etc)** | Please explain:<br>When? |
| | | **Emotional Issues**<br>**(i.e. anxiety, depression, PTSD, sleep issues)** | Please explain:<br>On medication? ____Yes ____No<br>If yes, please list: |
| | | **ADHD/ADD** | On medication? ____Yes ____No<br>If yes, please list: |
| | | **Hearing** | Repeated ear infections: ____Yes ____No<br>Hearing Aid: ____Yes ____No ____Tubes in ears<br>____Right ____Left ____Both |
| | | **Vision** | Wears glasses: ____Yes ____No Wears contacts: ____Yes ____No |
| | | **Dental Health** | Has your child been seen by a dentist? ____Yes ____No<br>If yes, last dental appointment: |
| | | **Other health conditions/issues?** | List condition and any medications: |

I give permission for release of information from my child's health record for confidential use in meeting my child's health and educational needs in school. Medical Alert information will be provided to appropriate school personnel responsible for my child during the school day.

Signature of Parent/Guardian: _____ Date: _____