[School Site] Nurse
[Phone Number]

FALLBROOK UNION ELEMENTARY SCHOOL DISTRICT
Health History - Student Annual Update

School Year
2017-18

Student Name: ______________________________ **Gender:** __________

Teacher: ______________________________ **Grade:** __________ **Birthdate:** ____ ______ ___

Father's Name/Legal Guardian: ____________________ **Home Phone:** ________________ **Work Phone:** ______________

Mother's Name/Legal Guardian: ____________________ **Home Phone:** ________________ **Work Phone:** ______________

*MUST CONTACT SCHOOL NURSE – ADDITIONAL FORMS NEEDED FOR SCHOOL.

MEDICAL HISTORY	YES	NO	NOTES/EXPLANATION
Asthma			Inhaler Prescribed? □No □**Yes***
Epilepsy/Seizures			Diastat Prescribed? □**No*** □**Yes*** Date of Last Seizure:
Severe Allergy			EpiPen/Medication Prescribed? □No □**Yes*** (Please Explain Below) If Yes, When was the EpiPen last used? ________________
Food Allergy			EpiPen/Medication Prescribed? □No □**Yes*** (Please Explain Below) If Yes, When was the EpiPen last used? ________________
Seasonal Allergies			Medication Required at school? □No □**Yes*** (Please Explain Below)
Diabetes			Medication Prescribed? □**No*** □**Yes*** (Please explain Below)
Medication Taken at Home?			Name of Medication:
Eye Problems/Glasses			Wears Glasses? □No □Yes Date of Last Eye Exam:
History of Recent or Serious Injury/Operation?			
Digestive Disorder			
Endocrine Disorder			
Hearing Problems			
Speech Disorder			
Urinary/Kidney Problems			
Heart/Blood Condition			
Orthopedic Problems			
Emotional Concerns			
ADD/ADHD			
Other:			

Known Allergies (Please describe trigger & allergic reaction): ____

____

Medications Needed at School* (Name, Time, Dose & Reason, Doctor's Note Required):______________________________

____

Any P.E. Restrictions? (Doctor's Note Required):____

____

Are there any problems you would like to discuss with the school nurse?____________________________

Physician/Doctor:______________________________________ Phone:______________________________

I hereby certify that the health history of this child is correct to the best of my knowledge and agree to the disclosure of my child's health information between FUESD and external health care professionals.

______________________________ ______________________________

Signature of Parent/Guardian Date