Buhler USD 313
Student Health History

Student Name: ______________________________ Birth date: ______________

School: ______________ Grade: ________ Physician: Dr. ______________

Dentist: Dr. ______________ Has your child been to the dentist within the last 12 months? ☐ Yes ☐ No

If no, would you like your child to receive a dental screening during the school year? ☐ Yes ☐ No

Please mark (x) any health problems and/or physical conditions that pertain to your child. This information enables school personnel to be more aware of health-related concerns and provide more personalized health care as needs arise. After completing this form, please sign and date the form at the bottom of the page and return to your child's school.

☐ My child has no known health concerns.

Eyes

☐ Wears glasses ☐ Wears contacts

☐ Blind right eye ☐ Blind left eye

Ears

☐ Frequent ear infections ☐ Wears hearing aide

☐ Deafness right ear ☐ Deafness left ear

☐ Ear surgery—Date: ______________

Type: ______________

Lungs

☐ Asthma ☐ Bronchitis

☐ Inhaler (see below) ☐ Nebulizer

-- My student will need to use inhaler at school Yes or No (circle)

If Yes, ☐ keep inhaler in office ☐ student will self carry

☐ asthma packet given ___/_____/____

(Separate forms must be signed. See office.)

Medications: ______________

____

Allergies

☐ Food ☐ Seasonal

Type: ______________

☐ Bee/Wasp sting ☐ EpiPen

Medications for treating allergies: ______________

____

☐ Drug allergies to ______________

Neurological

☐ Seizures ☐ Headaches ☐ Tourettes

Type: ______________

☐ Other: ______________

☐ Medications: ______________

ADHD/ADD

☐ ADHD/ADD, Depression, Bipolar, Anxiety, ODD

Type: ________ Diagnosed by Dr. ______________

Name & Time of Medication: ______________

Diabetes

☐ Type 1 ☐ Type 2

☐ Insulin ☐ Medication

Hypoglycemia

Medications: ______________

Times: ______________

Heart

☐ Mitral valve prolapse ☐ High blood pressure

☐ Congenital heart defect ☐ Murmur

☐ Surgery—Date: ______________

Type: ______________

☐ Restrictions: ______________

Orthopedic

☐ Osgood Schlatter's disease ☐ Scoliosis

☐ Other: ______________

Digestive

☐ Heart burn/indigestion ☐ Reflux

☐ Food intolerance ☐ Other

Comments: ______________

Other Physical/Mental Illnesses

Type: ______________

Medications: ______________

I give permission to share health information with staff on a need to know basis.

______________________________ ______________

Signature of Parent/Guardian Date

☐ Yes ☐ No I give the school nurse permission to share my child's immunization information with the Kansas Immunization Program and Kansas Web registry (KSWebIZ) for purposes of assessment and reporting to prevent disease.