STUDENT HEALTH HISTORY

Student's Name: ____DOB: __________ Grade: ______

TO BE COMPLETED BY PARENT.

_____My child is healthy and has no special health concerns.

_____My child has NO known allergies.

GENERAL HEALTH CONCERNS: ***Please (x) any of the following conditions your child has:***

- **Diagnosed ADD or ADHD since: _____If yes, What Medications are Prescribed?________________will they be needed at school (circle) Yes/ No When?______**
- **Allergies:**(food,insects,pets)**Please List**: ____
- What happens? ____
- **Epi-Pen Needed**? *(circle)* **Yes / No**

*****If you answered yes to this question, please contact the nurse directly, sign a medication administration sheet & supply your child's school with their Epi-Pen (in the original box with a prescription label) prior to the first day of school**

- **Asthma** – is inhaler used? *(circle)* **Yes No** How often? ________________________________
- **List all medications taken for Asthma**: ____
- **Heart Problems?**_ ____
- **Diabetes?** Age it was diagnosed: _______ Doctor's Name: _____________________________
- **Seizure disorder?** Last seizure date: ________ Medication: ___________________________
- **Surgeries?** ____
- **Concussion/Fractures?: Date and Type:** ____
- **Emotional Concerns? If yes, Medications:** ______________________________________
- **Any other Health Concerns?** ____
- **Medications?** ____

NursesNotes:____

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Owasso Public Schools can provide information regarding the students Health History to school employees supervising or transporting the student.