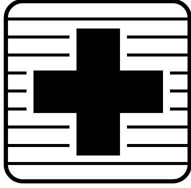

School District of Tomorrow River **2013-2014**

Emergency Illness-Health History Form

(To Be Completed By Parent/Guardian)

The information provided is confidential. This information is necessary for the health and safety of the student to assist in promoting optimal healthcare to facilitate the academic success of each student. Thank you for your time.

NAME OF CHILD: ____
Last First Middle

ADDRESS: ____
Street City State Zip

HOME PHONE NUMBER: ____________________ E-MAIL ADDRESS: ____________________

DATE OF BIRTH: ______________ GRADE: _______ TEACHER: ________________ MALE:______ FEMALE:______

FATHER'S (GUARDIAN) NAME: ______________________________ CELL #: ____________________
Last First

FATHER'S (GUARDIAN) EMPLOYER: ______________________________ WORK #: ____________________

MOTHER'S (GUARDIAN) NAME: ______________________________ CELL #: ____________________
Last First

MOTHER'S (GUARDIAN) EMPLOYER: ______________________________ WORK #: ____________________

EMERGENCY CONTACTS:

1. NAME: ______________________ RELATIONSHIP: ____________ PHONE #: ____________
   Last First

2. NAME: ______________________ RELATIONSHIP: ____________ PHONE #: ____________
   Last First

DISEASE/DISORDER HISTORY OR ILLNESS: Please check any of the following that apply.

	Yes	No		Yes	No
Allergies/Environmental			**Eating Disorder**		
Allergies/Food			**Endocrine Disorder**		
Allergies/Insect Stings or Bees			**Head or Spinal Injury**		
Allergies/Latex			**Headaches/Migraines**		
Allergies/Medications			**Hearing Problem**		
Allergies/Other:______________			**Heart Defect or Disease**		
Asthma/Breathing Disorder			**Hepatitis or Liver Problem**		
Behavioral Disorder			**Hypertension**		
Bladder/Kidney Disorder			**Immune System Disorder**		
Bleeding/Clotting Disorder			**Mobility Limitation**		
Bone/Joint/Muscular Disorder			**Psychological/Emotional Problem**		
Cancer			**Scoliosis**		
Convulsions/Epilepsy/Seizure			**Skin Condition**		
Developmental Disorder			**Urinary/Bladder/Kidney Disorder**		
Dizziness or Fainting			**Speech Disorder**		
Diabetes			**Surgery or Hospitalization**		
Dietary Restriction			**Vision or Eye Disorder**		
Digestive/Bowel Disorder			**Other (explain below)**		

Please turn page over and complete the other side

Was a medical evaluation performed for any condition/disorder checked 'yes' on the previous side: Yes______ No______

If Yes, which medical condition/disorder? ____

Child's Physician: ________________________ Phone number:_______________________ Date of Last Exam:______________

Child's Dentist: __________________________ Phone number:_______________________ Date of Last Exam:______________

MEDICATION HISTORY:

What medication does your child take on a daily basis (include homeopathic and nutritional supplements)? ____ NONE

Medication Name: _______________________ Used to treat:___________________________ Taken at School: ___YES* ____NO

Medication Name: _______________________ Used to treat:___________________________ Taken at School: ___YES* ____NO

Medication Name: _______________________ Used to treat:___________________________ Taken at School: ___YES* ____NO

Medication Name: _______________________ Used to treat:___________________________ Taken at School: ___YES* ____NO

**Medications that are going to be taken at school require medication consent forms to be completed and returned to school. Over-the-counter medications need only parental/guardian consent. Any prescription medications need consent from a parent/guardian and also written consent by a health care provider. These forms can be obtained in the school offices or printed online off the school website.*

SOCIAL HISTORY:
Have there been any changes in your family during the past year, such as:
Separation, divorce, or remarriage? Yes □ No □
Death or serious illness? Yes □ No □
Any other situation, which may affect your son/daughter? Yes □ No □

If yes, please explain:____

____

MISCELLANEOUS:
Please list any condition, special considerations and/or restrictions that your child may have which might limit his/her activities in school. Please include any comments that you think might be helpful:
____

____

____

☐ YES ☐ NO **CONSENT TO SHARE INFORMATION**: The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: ____ Date: __________________

Thank you for completing this form