Summer School-Health History 2017

Student's Name: _____ **Grade**_____ **ID#:** _____
Last Name First Name

Date of Birth: _____ **Last Killeen School Attended:** _____

My child's previous school was in the state of Texas. Yes No (circle one)

The following information will be on file in the school clinic. Please complete this form carefully. This information will be available to your child's teachers and support personnel. Contact the office if information changes concerning emergency contacts or your student's medical information.

HEALTH HISTORY

Please check the problems that apply to your child. ***A doctor's note may be required for modifications***.

___ **NO HEALTH PROBLEMS**

___ Glasses/Contacts (circle one)

___ Asthma

___ ADD/ADHD

For Allergies to food – please complete attached form.

In order for the cafeteria to make any substitutions, we must have a doctor's note which follows the TDA policy.

___ Allergies to medication
Specify: _____

___ Allergies to insect
Specify: _____

___ Allergies to other
Specify: _____

___ Epi-pen(furnished by parent) needed for: _____

___ Allergies-seasonal/hay fever

___ Diabetes: **Please notify the Campus Nurse for paperwork**

___ Chronic medical condition
Specify:_____

___ Eczema

___ Kidney/Bladder
Specify: _____

___ Migraines (Dr. verified)

___ Heart Condition (Any Restrictions?)
Specify:_____

___ Physical Restrictions Specify: _____
A doctor's note is required if the student has recurring health problems or needs to restrict his/her activities more than 3 consecutive days, i.e. a broken bone

___ Seizures: Specify: type/last seizure_____

___ Takes medication at home
Specify: _____

___ Takes medication in school clinic
Specify: _____

___ Takes medication-self-administered (*secondary only*)
Specify: _____

___ Severe Head Injury: Specify:_____

___ Emotional Condition
Specify: _____

___ Counseling: Specify:_____

___ Positive T.B. test

___ Sickle Cell Anemia

___ Scoliosis

___ Visual Handicap/Blind
Specify: _____

___ Hearing Handicap/hearing aides/deaf
Specify: _____

___ Other Health Problem
Specify: _____

KISD has a standing physician's order to use the following over-the-counter topical medications in the school clinic for minor first aid if a student does not need to go home or see a physician. **I give approval for these medications to be used to treat my student while he/she is in school. Please cross out those that cannot be used on your child.**

Calamine
Normal saline/isotonic solutions for eye wash
Petroleum jelly for chapped lips
Zephiran for wound cleansing

Signature of Parent or Guardian Date

Relationship to Student Daytime Phone #

Clinic Log on Health History

Student's Name:_____ **Campus**_____

Date	TI	TO	Complaint	Temp	Disposition/Treatment	Init

Code: H/A=Headache S/A=Stomachache C/S=Cuts/Scrapes S/T=Sore throat N=Nausea V=Vomited C/B=Cleanse/ Bandaid B/C= Back to class H=Home R=Rest E/L=Eat lunch WP=Wet pants B/A=Bandaid

Signature	Initials	Date	Signature	Initials	Date