THE GREATER ALLEGHANY SCHOOL HEALTH PROJECT

Student Health History Form _____(School Year)

Please complete **entire** form, sign, and return to school as soon as possible.

Name: (Last)_____ (First)_____ (MI) _____ **Sex**: M or F **Grade:** _____

Birthdate: ____/_____/____ **HR Teacher**: _____ **Address**: _____

Parent/Guardian* (Call 1st)**:_____Relationship to Student***_____
Home #_____ **Work #**_____ **Cell #**_____
Parent/Guardian* (Call 2nd)**:_____Relationship to Student***_____
Home #_____ **Work #**_____ **Cell #**_____

Emergency contact names/numbers if parent listed above cannot be reached:
1. **Name**: _____ **Relationship**_____ **Home#**_____**Work#** _____ **Cell #** _____

2. **Name**: _____ **Relationship**_____ **Home#**_____**Work#** _____ **Cell #** _____

Physician: _____ **Dentist:** _____

Your child has the following health insurance (Please circle all that apply): **Private** **Medicaid** **FAMIS** **None**

Please circle all that apply to student:

Allergies / Hayfever (list below)	Bleeding / Clotting Disorder	Head Injury / Concussion	Orthopedic / Bone
Bee Sting / Insect Allergy (list below)	Cerebral Palsy	Headaches	**Medication Allergies / Reaction (list below)**
ADHD	Chickenpox	Hearing Loss	Psychological / Psychiatric Treatment
Anemia (include Sickle Cell)	Cystic Fibrosis	Heart Condition / Murmur	Scoliosis
Arthritis	**Diabetes**	Hypertension	**Seizures**
Asthma	**Food Allergy (list below)**	Lead Exposure	Skin Disorders
Bladder / Kidney Disease	Gastro-intestinal	Mononucleosis	Vision Loss / Correction

Please give details / dates of all conditions checked above and other health conditions not listed. _____

_____

_____

Is your child taking medication (Prescription or Over-the-Counter)? Yes _____No_____ **If Yes, complete the following**:

Name:_____ Dosage:_____ Reason for use:_____

Name:_____ Dosage:_____ Reason for use:_____
(If more than two, please list below.)

*I give permission for my child to have the following medications if the nurse/school personnel feel it is necessary. I understand and accept that the Alleghany County/Covington School Boards, its employees, agents or designees are not responsible for any effects of the medication administered.

Tylenol: Yes No **Benadryl: Yes No** **Cough Drops: Yes No**

*I give permission for the nurse to share information with administration/faculty regarding health problems that may require emergency intervention. **Yes No**

*I give permission for my child to be transported to the hospital in the event of an emergency. **Yes No**

*I authorize my child's health care provider and designated provider of health care/school official to discuss my child's health concerns and/or exchange information. You may withdraw your authorization at any time by contacting your child's school. **Yes No**

Please see school handbook in regards to medications at school and on the bus.

Parent/Guardian Signature _____ **Date**_____ rev 02/16