Student Health History

Student Name: _____ DOB: _____

Teacher: _____ School: _____

Rides CVUSD Bus: ▢ Yes ▢ No
Attends EDP: ▢ Yes ▢ No

Medication At School

Any student who is required to take medication during the school day must have a valid physician order on file in the Health Office. The parent/guardian must provide the medication(s) in the prescription container(s) which is labeled with the student's name, the prescribing physician's name, the dosage, times to be given and monitoring devices (if needed) and confirm that medication containers are labeled in a manner that is consistent with the written physician order. The parent/guardian must notify the District Nurse or other designated school personnel if there is a change to the student's medication, health status or authorized healthcare provider.

Student Specific Information

Select any boxes below that apply:

▢ My child requires medication at school: Medication Name: _____ Reason:_____

▢ Allergies: Must select all that apply.

- ☐ Environmental Allergies: (e.g. Dust/Pollen) Description: _____
- ☐ Food Allergies:
  - List Foods: _____
  - List Symptoms: _____
  - Epipen Prescribed: ▢ Yes ▢ No Antihistamine ▢ Yes ▢ No
- ☐ Insect sting:
  - List Insects: _____
  - List Symptoms: _____
  - Epipen Prescribed: ▢ Yes ▢ No Antihistamine ▢ Yes ▢ No
- ☐ Latex:
  - List Symptoms: _____
  - Epipen Prescribed: ▢ Yes ▢ No Antihistamine ▢ Yes ▢ No
- ☐ Medication: (e.g. allergy to Amoxicillin) Medication Name: _____

▢ Asthma: Inhaler needed at school? ▢ Yes ▢ No

▢ Attention Deficit/Hyperactivity Disorder: ▢ ADHD ▢ ADD

▢ Diabetes: ▢ Type 1/ Insulin Dependent ▢ Type II ▢ Hypoglycemic

▢ Hearing Difficulty: ▢ Wears assisted hearing device ▢ Right Ear ▢ Left Ear

▢ Heart Condition: Activity Restrictions ▢ Yes ▢ No Pacemaker ▢ Yes ▢ No

▢ Vision Impairment – Wears glasses ▢ Wears contacts ▢

▢ Seizures: Frequency: _____ Describe: _____

Emergency Seizure Medication Prescribed: ▢ Yes ▢ No If yes, name of medication:_____

VNS ▢ Yes ▢ No If yes, location: _____

▢ Cancer: Currently receiving treatment? ▢ Yes ▢ No

▢ Tracheostomy

▢ Serious Head Injury Age: _____ Description: _____

▢ Sickle Cell Disease

▢ Shunt: Location: _____

▢ Urinary Catheterization: Type: _____ Frequency: _____

▢ Feeding tube: Type: _____ Pump: ▢ Yes ▢ No

▢ Mobility Impairment: ▢ Wheelchair ▢ Walker ▢ Other/Limitations: _____

List any other health information you would like the District Nurse to be aware of: _____

_____

_____

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact his/her learning. I understand that medications of any kind (i.e. Tylenol, cough drops, eye drops, nasal spray) are not allowed on school grounds without a valid physician order on file. I understand that school staff, including the School Nurse, MAY NOT administer or assist with any medication without the valid physician order on file. I understand that for the safety of my child, the School Nurse may need to share information about my child's health condition with appropriate school staff. This will be done in a confidential manner according to The Family Educational Rights and Privacy Act (FERPA). If I do not wish that information be shared, I must request this in writing and send the request to the School Nurse.

Signature: _____ Relationship: _____ Date: _____