

Part III – Medical History

<input type="checkbox"/> YES <input type="checkbox"/> NO	KNOWN HEALTH PROBLEMS If NO, go directly to the bottom of the page and provide parent/guardian signature If YES, and diagnosed by a physician, answer each question below.
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD) Requires medication <input type="checkbox"/> At school <input type="checkbox"/> At Home
<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies: <input type="checkbox"/> Food _____ <input type="checkbox"/> Hives/rash <input type="checkbox"/> Medications <input type="checkbox"/> Insects _____ <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Epi-pen <input type="checkbox"/> Environmental _____ <input type="checkbox"/> Medications _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma <input type="checkbox"/> Uses an inhaler at school <input type="checkbox"/> Uses an inhaler at home
<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood/Bleeding Problems: <input type="checkbox"/> Hemophilia, <input type="checkbox"/> Von Willebrand's, <input type="checkbox"/> Other <input type="checkbox"/> Requires medication <i>Please explain:</i> _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Nose Bleeds: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer/Leukemia: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cystic Fibrosis: <i>Please explain</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Monitors Blood Sugars at school <input type="checkbox"/> Requires Insulin at school <input type="checkbox"/> Insulin pump <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Managed with diet <input type="checkbox"/> Glucagon order <input type="checkbox"/> Oral medication
<input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional/Behavioral/Psychological: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal/Stomach Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Genetic / Rare Disorders: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing Problems: <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aid <input type="checkbox"/> Tubes <input type="checkbox"/> Cochlear Implant
<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Condition: <input type="checkbox"/> Activity restrictions: <input type="checkbox"/> Medications taken at home: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension (High Blood Pressure): <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney/ Bladder/ Urinary Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Scoliosis: <input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Family History
<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures/Convulsions: Type of seizure: _____ Medications: <input type="checkbox"/> Diastat <input type="checkbox"/> Klonopin <input type="checkbox"/> Versed <input type="checkbox"/> Medication taken at home <input type="checkbox"/> Other _____ <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell: <input type="checkbox"/> Anemia <input type="checkbox"/> Trait
<input type="checkbox"/> YES <input type="checkbox"/> NO	Shunt: <input type="checkbox"/> VP shunt <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida:
<input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Vision Problems: <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other
<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Conditions: <i>Please include <u>any</u> medications taken at home only.</i>

Required Signatures

Signature of parent(s) or guardian: _____
Date: _____
Signature of school nurse: _____
Date: _____