# MIDLAND SCHOOL STUDENT HEALTH HISTORY

PARENTS/GUARDIANS TO COMPLETE

**CHILD'S NAME:** _____ **DATE OF BIRTH:** _____

**PERSON COMPLETING FORM/RELATIONSHIP**_____

**DATE OF FORM COMPLETION**_____

**CHILD'S MEDICAL DIAGNOSIS:** _____

**MEDICATIONS:**

Medication Dose Frequency

_____

_____

_____

**MEDICATION/FOOD ALLERGIES:** No Yes

If yes, to what and what was the reaction_____

**SPECIAL DIET OR FOODS TO AVOID:** _____

**HAS YOUR CHILD HAD A G-TUBE OR DIFFICULTY SWALLOWING:** _____

_____

**PERSONAL MEDICAL HISTORY:**

Please check if your child has had any of the following medical problems:

| | | | |
|---|---|---|---|
| □ADD/ADHD | □Cancer | □Headaches | □Liver disease/Hepatitis |
| □Stroke | □Concussion | □Hearing problems | □Recurrent ear infections |
| □Anemia | □Diabetes | □GU Disease | □Seizures |
| □Asthma | □Eczema | □Congenital heart disease | □Urinary Tract Infections |
| □Bleeding disorder | □Fracture | □High blood pressure | □Cerebral Palsy |
| □Lyme Disease | □GI disease | □Kidney disease | □Psychiatric illness |

**HOSPITALIZATIONS:**

Has your child every stayed overnight in a hospital? □No □Yes

**BEHAVIOR:** Please describe any behavior issues your child is currently having and how they are being managed: _____

_____

_____

**SURGICAL HISTORY:**
Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

_____

**DIABETES:** How often does your child check their blood sugar? _____

_____

**CARDIAC HISTORY:** Has your child had a history of cardiac surgery or problems? _____

_____

**SEIZURES:** Please describe the type of seizure, frequency and length of your child's seizures: _____

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**NAME & NUMBER OF PEDIATRCIAN:** _____

**NAME & NUMBER OF PSYCHIATRIST/NEUROLOGIST:** _____

**NAME & NUMBER OF OTHER MEDICAL SPECIALIST:** _____

***I hereby authorize the Midland School Nurses to discuss the health information of my child with the above medical providers as it pertains to medical care being given at school.***

**Parents signature:** _____ **Date:** _____

**Is your child continent of their bowel and bladder? (if not explain):** _____

_____

**MOBILITY REQUIREMENTS:** Does your child use a walker, wheelchair, Riftin chair, etc.? _____

_____

**Does your child have orthotics or prosthetic devices?** _____

**Does your child wear glasses? ____Y ____N Does your child have dental braces? ____Y _____N**

**ANY OTHER INFORMATION YOU WOULD LIKE TO SHARE:** _____

_____

_____

**Does your child have health insurance? _____Y _____N Name of insurance:** _____

***I hereby give consent to the school nurse to share the information included in this form with the appropriate Midland School staff members.***

**Parent's Signature:** _____ **Date:** _____

Midland School RN: _____ Date : _____