

Student Health Information Sheet

Manchester, Poplar Grove, Capron, Upper Elementary, Middle School, High School

Name: _____ Grade: _____
Last First Middle

Address: _____
Street P.O. Box

City State Zip

Personal: _____
Birth Date Sex

Names of Parents / Guardians

Health History to be Completed and Signed by Parent/Guardian

Diagnosis of Asthma? (If yes, fill out Form 7:270-E2) Wheezing/Cough with activity?	Yes/No Yes/No	Hospitalizations? For What & When _____	Yes/No
Carry Inhaler? Type _____	Yes/No	Surgery? For What & When _____	Yes/No
Birth Defects? Specify _____	Yes/No	Serious Injury or Illness?	Yes/No
Developmental Delay? Specify _____	Yes/No	Loss of One of Paired Organs?	Yes/No
Blood Disorders? Specify _____	Yes/No	TB Skin Test Positive? TB Disease? (Past or Present)	Yes/No Yes/No
Diabetes? (If yes, fill out Forms 7:270-E5, E6, E7)	Yes/No		
Head Injury/Concussion?	Yes/No	Alcohol/Drug Use?	Yes/No
Seizures? Type _____	Yes/No	Tobacco Use? Type/Frequency _____	Yes/No
Heart Problems/Short of Breath? Specify _____	Yes/No	Family History of Sudden Death Before Age 50? Cause _____	Yes/No
Heart Murmur/High BP?	Yes/No	Dental: Braces/Bridge/Plate?	Yes/No
Dizziness/Chest pain with Exercise?	Yes/No	Dental: Other _____	Yes/No
Bone/Joint Problems/Injury? Specify _____	Yes/No	Allergies? To _____	Yes/No
Scoliosis?	Yes/No	(Food Allergies – Fill out Form 7:270-E10)	
Ear/Hearing Problems? Which ear? _____	Yes/No	(Other Allergies – Fill out Form 7:270-E4)	
Eye/Vision Problems? Specify _____ Glasses/Contacts Last Exam _____	Yes/No	Any Other Concerns? _____ _____ _____	Yes/No

Please use back of form for additional information from this page if needed.

Health History Continued:

Health Condition(s):	Additional comments:
Any medication taken at home?	No Yes: List:
Any medication taken at school? (If yes, fill out Form 7:270-E1)	No Yes: List:

Initialize below:

_____ I acknowledge that if my child keeps medication at school, I have filed a School Medical Form (7:270-E1) with the school nurse.

_____ I authorize the School District, and its employees and agents, to take the action they believe is appropriate in an emergency.

Hospital of Choice _____

Doctor's Name _____

Doctor's Phone Number _____

_____ I agree to indemnify and hold harmless the School District, and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the emergency care of my child.

_____ I authorize this health information to be shared with appropriate school staff.

Does your child have school insurance? Yes No

Is your child covered by other insurance? Yes No

If yes, identify the company and insurance number _____

Parent(s) / Guardian(s) Printed Name

Relationship to Student

Parent(s) / Guardian(s) Signature

Date