

BENTON COUNTY SCHOOLS' STUDENT HEALTH HISTORY

Hickory Flat Attendance Center 662-333-7731 / Ashland High School 662-224-6247 / Ashland Elementary School 662-224-6622

*Superintendent, Pete Howell * Benton County School District Central Office -662-224-6252 * Asst. Superintendent, Pam Gray*

This form is necessary to inform the school of your child's health status and to plan for health needs that may impact their school day. All health information is considered confidential. It may be shared with staff as needed during the time your child is enrolled here in order to ensure the health and safety of your child. Information provided on this form is protected by the Family Educational Rights and Privacy Act (FERPA) as part of the student's educational record and securely stored at the school in your child's permanent file.

SECTION I * DEMOGRAPHICS

Student Name _____ Grade _____ Male _____ Female _____
 Date of Birth _____ Age _____ Height [feet/inches] _____ ft _____ in / Weight _____ [pounds]
 Address _____ City _____ State _____ Zip-code _____
 Parent/Guardian _____ Phone# _____
 Parent/Guardian's Email _____ Alternate Phone # _____
 Student's Health Care Provider _____ Phone# _____ Fax# _____
 Health Ins. _____ Group # _____ Medicaid# _____
 List Medication Allergies: _____

I consent to my child's Health Care Provider(s) and the School Nurse discussing the information on this form. A copy of this form may be released to my child's Health Care Provider or Emergency Services if requested.

Signature _____ Date _____

SECTION II * Student Medical History

ASTHMA

Does your child have asthma? **YES NO** Will your child require the use of an **Emergency Rescue Inhaler** while at school? **YES NO**
An ASTHMA CARE PLAN (a new Doctor's order) is REQUIRED to be on file at the start of each school year for all students who require an Emergency Rescue Inhaler for their ASTHMA.

Where a condition would put your child in danger of death during the school day, a medication-treatment order-care plan, should be obtained each year before school starts.

ALLERGIES Does your child have Seasonal Allergies? **YES NO**
 Does your child have Allergies to: Grass / Trees / Nuts / Carpet / Dust / Mold / Perfumes / Insect Bites / Bee Stings / Cats / Dogs etc...

Please list all food allergies: _____

LIFE THREATENING ALLERGIES

Does your child have Life Threatening allergies (COULD CAUSE DEATH) requiring EPIPEN use? **YES NO** (please list above)
An ALLERGY CARE PLAN (a new Doctor's order) is REQUIRED to be on file at the start of each school year for all students with LIFE THREATENING ALLERGIES

Where a condition would put your child in danger of death during the school day, a medication-treatment order-care plan, should be obtained each year before school starts.

EPILEPSY/SEIZURES Does your child have epilepsy or seizures? **YES NO** **If yes, your child needs an Epilepsy / Seizure care plan.**

DIABETES Does your child have diabetes? **YES NO** **If yes, your child needs a Diabetic Care Plan.**

Where a condition would put your child in danger of death during the school day, a medication-treatment order-care plan, should be obtained each year before school starts.

EMERGENCY MEDICATIONS Will your child need emergency medications at school? **YES NO**
 [EPIPEN] [BENADRYL] [RESCUE INHALER] [DIASTAT] [GLUCAGON] [NONE] (please select all that apply)

DAILY MEDICATIONS Will your child need to take daily medications at school? **YES NO** (Please list)

If your child needs daily and / or emergency medications at school, each medication will need a Medication Consent Form on file at the school. These forms are available in the nurse's office. You are responsible for supplying the medication.

List additional medical history: such as ADHD, GERD, Migraines, NoseBleeds, Sickle Cell, Bipolar, Kidney/Bowel/ Heart condition etc...

List other medications your child takes at home: _____

PARENT/GUARDIAN SIGNATURE

DATE

*****NO SICK OR INJURED CHILD WILL BE ALLOWED TO RIDE HOME ON THE BUS*****