



Houston County Student Health Record

Health Related Service

Student's Name: _____ Student's ID #: _____ DOB: _____

School: _____ Grade: _____ Home Room Teacher: _____ Date: _____

Does this student have any medical concerns? Yes (Complete Form) No (Stop Form Here)

Allergies (medication, food, insect, environment): _____

What kind of reaction occurs with these allergies? _____

Has your student ever had an Anaphylactic Reaction? Y N EMERGENCY Injectable Epinephrine Y N
Student Carries / In Clinic

Student's Current Medical History: (Check All That Apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Limb Loss |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cardiac <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Missing Organs (eye, kidney, etc.) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Crohns/IBS | <input type="checkbox"/> Pacemaker or <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Asthma: <input type="checkbox"/> Y / <input type="checkbox"/> N | <input type="checkbox"/> Convulsions w/Fever | <input type="checkbox"/> Premature Birth (Complications) |
| <input type="checkbox"/> Inhaler: at School <input type="checkbox"/> or Clinic <input type="checkbox"/> | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Seasonal | <input type="checkbox"/> Diabetes: _____ <input type="checkbox"/> Glucagon | <input type="checkbox"/> Seizures: (Type): _____ |
| <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Insulin injection or <input type="checkbox"/> Pump | <input type="checkbox"/> Diastat _____ VNS _____ |
| <input type="checkbox"/> Trigger(s): _____ | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Sickle Cell Condition |
| <input type="checkbox"/> Auto Immune Disorder | <input type="checkbox"/> Frequent Headaches/Migraines | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Bleeding Problems/Blood Disorder | <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Blood Pressure: | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Surgery/Hospitalization |
| <input type="checkbox"/> High | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems/Contacts |
| <input type="checkbox"/> Low | <input type="checkbox"/> Heart Murmur/Type: _____ | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Bowel/Bladder Problem | <input type="checkbox"/> Heat Exhaustion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bronchitis (Chronic) | <input type="checkbox"/> Hemophilia | |

Describe how the above checked items affect your student at school (you may use back of form if needed).

Does your student have any potentially life threatening condition(s)? _____ If yes, please explain. _____

List all medication(s) the student takes (if taken at school, see Health Tech for form): _____

Has a doctor ordered any special dietary modifications? (See Health Tech for Meal Modification form, updated annually)

Current Physician: _____ Family Pediatrician: _____ Specialist: _____

Sign if you consent to the exchange of relevant medical information between the student's physician and the school nurse to include diagnosis, prognosis, treatment medical orders and records.

Signature: _____ Relationship to Student: _____

Date: _____

After School Program: _____

After School Daycare: (Name) _____

Car Ride: _____

Bus #: _____

