

STUDENT MEDICAL HISTORY 2020-2021



This Information will be given to the nurse only

This form must be completed annually

Name: _____ Nickname: _____

Date of Birth: _____ Grade: _____

Parents/guardians name & phone # _____

Doctor's name and phone # _____

Check Any That Apply (present and/or past): Please explain below in space provided.

Allergy to insects (Explain below)		Allergy to Food (Explain below)		Allergy to Pollen, Dust, Mold, etc. (Explain below)		Surgical history (Explain below)	
Cancer		Heart disease/irreg heart rhythm		Diabetes		High/Low BP	High Low
Eczema		Learning disability		Seizure disorder		ADD/ADHD	
Eating Disorder (Explain below)		Vision problems Glasses / Contacts		Hearing issues / Hearing aids	Right Left	Psychological problems	
Fainting		Headache/Migraine		Bleeding disorder		Behavior problems	
Depression		Suicidal thoughts		Speech problems		Anxiety	
Birth defect		Blood disorder		Cerebral Palsy		Chronic Pain	
Asthma/Lung problems		Chicken pox (year: _____)					

Explanations to any checked condition:

Allergies

1. Food allergy: Food _____

If yes, what type of reaction and treatment

*If reaction is severe and requires medication, please see nurse for severe food allergy questionnaire and action plan.

Please complete reverse side

STUDENT MEDICAL HISTORY 2020-2021



2. Medication allergy

Reaction _____

3. Insect allergy _____

Reaction _____

Surgical History

Explanation of above conditions or other concerns

List medications student is taking _____

* SCA policy requires written permission from a parent/guardian before any medication, prescription or over-the-counter, may be given at school. An Authorization to Dispense Medication Form is available on our website and in the nurse's office. All medication must be in the original container. It will only be dispensed according to package directions unless otherwise specified by a doctor.

**First-aid is administered according to our Elementary & Secondary Handbook.