# Edwards County Community Unit # 1
## Health History Form for New Students
## School Year 2023-24
***Confidential Information***

Student's Name_____ Grade _____ School _____
Last First

**Please indicate Yes or No if your child is currently or has been in the past, affected by any of the following items. Please add additional information that would be beneficial to the School Nurse. Use the back side of the form if needed.**

| | | | | |
|---|---|---|---|---|
| Chicken Pox Disease | Yes | No | → | If yes, Month & Year of Disease_____ |
| Birth Defects | Yes | No | → | Type_____ |
| Developmental Delay | Yes | No | → | Type_____ |
| Blood Disorder | Yes | No | → | Type_____ |
| Sickle Cell Anemia | Yes | No | → | Explain_____ |
| Diabetes | Yes | No | → | Medication/Diet_____ |
| Epilepsy/Seizures | Yes | No | → | Type_____Meds_____ |
| Heart Problems | Yes | No | → | Type_____Meds_____ |
| Asthma | Yes | No | → | Uses Inhaler Yes No (If yes, please see the nurse.) |
| ADD | Yes | No | → | Medication_____ |
| ADHD | Yes | No | → | Medication_____ |
| Hearing Difficulty | Yes | No | → | Wears Hearing Aid(s) Yes No |
| Speech Problems | Yes | No | → | Ever had speech therapy Yes No |
| Ear Infection | Yes | No | → | Have tubes now: Yes No Ever had tubes: Yes No |
| Vision Difficulty | Yes | No | → | Currently wears: Glasses Contacts None |
| Medication Allergy | Yes | No | → | If yes, please list_____ |
| Food Allergy | Yes | No | → | If yes, please list_____ EpiPen: Yes No |
| Other Allergies | Yes | No | → | If yes, please list_____ |
| Special Diet | Yes | No | → | Type_____Restrictions_____ |
| Bone/Joint Problems | Yes | No | → | Explain_____ |
| Cystic Fibrosis | Yes | No | → | Med at School Yes No (If yes, please see the nurse.) |
| Muscular Dystrophy | Yes | No | → | Special Needs_____ |
| Multiple Sclerosis | Yes | No | → | Special Needs_____ |
| Cerebral Palsy | Yes | No | → | Special Needs_____ |
| Headaches | Yes | No | → | Medication_____ |
| Bowel Problems | Yes | No | → | Special Needs_____ |
| Urinary Problems | Yes | No | → | Special Needs_____ |
| Tumors/Cancer | Yes | No | → | Location/Med_____ |
| Mental Illness | Yes | No | → | Diagnosis/Med_____ |
| Depression | Yes | No | → | Medication_____ Therapy Yes No |
| Nervous/Anxious | Yes | No | → | Special Needs/Medication_____ |
| Sleep Disorder | Yes | No | → | Special Needs_____ |
| Surgeries | Yes | No | → | Type & Date_____ |
| Hospitalizations | Yes | No | → | Reason_____ |

Daily Medications_____

Other information_____

**In an emergency, if your child would need to be transported to the hospital, which hospital would you want them taken to? (Please circle) Fairfield Mt. Carmel Olney**

**EMS will only transport to the nearest hospital in an emergency situation.**
**They could later be transferred to another hospital in Evansville, Mt. Vernon, etc.**

*Please Read*

All medications must be kept in the nurse's office or the West Salem Grade School Office and in their original containers. A physicians' order is required for all medication given at school including over-the-counter medications.

** I understand that medication CANNOT be given to my child at school unless I have a physician complete the medication order form and sign at the bottom giving the school personnel permission to administer the medication. **

***Parent/Guardian Signature*_____ *Date*_____