Edwards County Community Unit # 1
Health History Form for New Students
School Year 2024-25
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***__________________________