TROY AREA SCHOOL DISTRICT HEALTH HISTORY **(to be completed by parent/guardian)**

STUDENT NAME_____sex_____Date of birth_____

Life Threatening Allergic Conditions: Check ALL that apply

( ) Severe allergic reactions to bee stings or other insects:_____
( ) Severe reaction to Nuts, Peanuts:_____
( ) Severe reaction to other food products_____

Please indicate any of your child's symptoms which would indicate a severe allergy:

( ) Itching and/or tightness in throat, hoarseness ( ) Itching or swelling of eyes, lips or tongue
( ) Shortness of breathe, coughing and/or wheezing ( ) Thready pulse, faintness/passing out
( ) Hives

Has your physician prescribed an Epi Pen or other medication for a life threatening allergy? ( )YES ( ) NO
Specify medication and dose_____

Health conditions: Has your child been diagnosed by a physician with any of the following? Check Yes or No. Provide dates and details for all items checked "Yes" on back side.

YES NO Condition

_____ Attention deficit ADD or ADHD
Date diagnosed_____Medications_____
_____ Allergies to medications Names_____
_____ Allergies (environmental / seasonal)
_____ Asthma Use an inhaler? Yes_____ No_____
Use a nebulizer? Yes _____ No_____
_____ Autism Spectrum Disorder_____ Aspergers_____
_____ Behavior problems
_____ Bleeding disorder
_____ Bowel or digestive problems
_____ Cancer Type_____Date diagnosed_____
_____ Cerebral Palsy
_____ Cystic Fibrosis
_____ Dental problems
_____ Depression
_____ Diabetes: Date diagnosed_____Insulin dependent ( ) YES ( ) NO
_____ Eating disorder Anorexia_____ Bulemia_____
_____ Emotional disorder
_____ Growth problems or developmental problems
_____ Heart/ blood pressure problems Specify_____
_____ Hepatitis Type and date diagnosed_____
_____ Hospitalizations: Specify_____
_____ Immunodeficiency disease
_____ Kidney or urinary problems or genital problems
_____ Lyme Disease
_____ Muscular disorder
_____ Migraine headaches
_____ Orthopedic (bone/joint) problems
_____ Pregnancy
_____ Scoliosis (curvature of the spine) date of diagnosis_____
_____ Seizure disorder Type_____
Date of last seizure_____Medications_____
_____ Self harm/mutilation
_____ Sickle cell disease
_____ Spina Bifida
_____ Substance abuse (alcohol, drugs, tobacco)
_____ Suicide risk or attempt
_____ Surgeries: Specify_____
_____ Thyroid disorder
_____ Tourette's syndrome
_____ Other **Complete other side**

DETAILS FOR ALL CONDITIONS MARKED "YES"

_____
_____
_____
_____
_____
_____
_____

SERIOUS ACCIDENTS _____
_____

HEARING

YES NO

Hearing loss:

_____
_____ (R)_____Mild _____Moderate_____Severe_____
_____ (L)_____Mild_____Moderate_____Severe_____
_____ Hearing aid ( ) Right ( ) Left

VISION

_____ Color deficiency
_____ Legally blind
_____ Vision problem / Eye defect_____
_____ Wears glasses ( ) all the time ( ) distance only ( ) reading
_____ Wears contact lens

MEDICATION

NAME OF ALL MEDICATIONS TAKEN: include all prescriptions and over the courter meds taken regularly

_____
_____
_____

NAME OF FAMILY DOCTOR_____Phone_____

Pennsylvania School Health mandates that annual screenings be done on all students.

YES NO

_____
_____ **Height and Weight** all grades
_____ **Vision Exam** all grades
_____ **Hearing exams** grades: kindergarten, 1,2,3,7, 11
_____ **Scoliosis** (spine curvature) grade 7
_____ **Physical exams** grades: kdg, 6 and 11 grades. You will be notified when they will be offered and have the option of having your family doctor complete this exam.
_____ **Dental exams** grades kdg, 3 and 7 if not completed by your family dentist

I give my permission for my child to have the mandated screening.

* **Parent/guardian signature**_____

Do you have any concerns about your child's health that were not included above that you want the school nurse to be aware of?

Do you give the school nurse permission to share this medical information with your child's teachers and/or coaches if the need arises?
YES_____NO_____

***Parent/guardian signature**_____Date_____