

**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 counter 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 \_\_\_\_\_