

**2008/2009 Trinity County Schools  
Confidential Student Health History**

**This health and development form must be completed by the parent or guardian at admission and prior to each school year. It will be reviewed by the school nurse. From this information a confidential health list will be generated and distributed to appropriate staff.**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Approx. date of last exam: \_\_\_\_\_

Name family dentist: \_\_\_\_\_ Approx. date of last exam: \_\_\_\_\_

Name of eye doctor: \_\_\_\_\_ Approx. date of last exam: \_\_\_\_\_

Do you have any health concerns you wish to discuss with the school nurse: \_\_\_\_\_

Does your child take any medication on a routine basis?  Yes  No  During school hours

Name of medication: \_\_\_\_\_ Purpose of medication: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Purpose of medication: \_\_\_\_\_

**Please contact the school office regarding the "Medications at School" policies  
if your child must take prescriptions or over the counter medications during the school day.**

**DISEASE AND DEVELOPMENTAL HISTORY**

Check  the box and explain if your child has a history of, or now has the following conditions or concerns.

- Anemia**
- Bone/Joint/Muscle problems** \_\_\_\_\_
- Chest Pains**
- Chicken Pox** – Month and Year \_\_\_\_\_  
 Vaccinated  Waiver on file
- Chronic Urinary Tract Infection** \_\_\_\_\_
- Diabetes**  Type I  Type II
- Irritable Bowel Syndrome**
- Headaches**  
 Due to eyes  Due to allergies  
 Unknown cause \_\_\_\_\_
- Heart Murmur/Disease** \_\_\_\_\_
- PE Activity Restrictions** \_\_\_\_\_
- Scarlet Fever**
- Seizures**  
 As an infant  Use medication  
 Use emergency plan if happens at school
- Tuberculosis**
- Whooping Cough**
- ADD/ADHD**  
 Medication at home  Medication at school
- Autism Spectrum Disorder**
- Behavior/Emotional Issues** \_\_\_\_\_  
 Overactive/shy  Separation anxiety  
 Trouble making friends  
 Medication at home  Medication at school
- Developmentally Delayed**
- Physical Limitations** \_\_\_\_\_  
 Special Equipment needed at home  
 Special Equipment needed at school
- Scoliosis**  
 Under treatment  Needs evaluation
- Speech Problems**  
 Enrolled in Speech Therapy

- Asthma**  
 Mild  Moderate  Severe  
 Rescue Inhaler at home  
 Rescue Inhaler with student  
 Rescue Inhaler in school office
- Allergies**  
 Mild  Moderate  Severe  
 Bees/insects  
 Foods \_\_\_\_\_  
 Seasonal Hayfever  
 Allergic to Medication \_\_\_\_\_  
 Other \_\_\_\_\_  
 EpiPen at home  EpiPen at school
- Frequent Ear Infections**  
 Ear Drainage  
 Tubes in ears  Left  Right  
 Hearing Loss  Left  Right  
 Hearing Aids  Left  Right
- Frequent Throat Infection**  
 Tonsils/Adenoids removed
- Frequent Colds**
- Frequent Nose Bleeds** \_\_\_\_\_
- Traumatic Brain Injury** \_\_\_\_\_
- Vision/Eye Problems**  
 Wears glasses or contacts  
 History of corrective eye surgery

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ *My child does not have any health issues at this time.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_