Anchorage School District

HEALTH HISTORY FORM

PLEASE COMPLETE FOR ALL NEW-TO-DISTRICT OR AS NEEDED

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

MEDICAL HISTORY (*If YES to any of the below, please follow-up with the school nurse*)

☐ **YES** ☐ **NO** **Does your child have any health concerns?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have restrictions to participate in any activities?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have any allergies?**
If yes, please list allergies: _____
What does the allergic reaction look like? _____

☐ **YES** ☐ **NO** **Is your child prescribed an EpiPen? For what allergies?** _____

☐ **YES** ☐ **NO** **Does your child have asthma?**
If yes, please describe type or triggers: _____

☐ **YES** ☐ **NO** **Does your child have diabetes?**
Type:_____ ☐Self manage ☐Needs supervision ☐Uses insulin pump ☐Uses CGM

☐ **YES** ☐ **NO** **Does your child have a heart condition?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have a bleeding disorder?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have an orthopedic condition?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have a history of seizures or another type of neurological disorder?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have any gastrointestinal concerns or issues with eating?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have any bowel or bladder concerns?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have behavioral, emotional, or mental health concerns?**
If yes, please describe: _____

☐ **YES** ☐ **NO** **Does your child have any vision concerns?** ☐ **GLASSES** ☐ Other: _____

☐ **YES** ☐ **NO** **Does your child have any hearing concerns?** ☐ **HEARING AID** ☐ Other: _____

☐ **YES** ☐ **NO** **Does your child currently take medications?**
If yes, please describe: _____
_____

DO ANY PRESCRIBED MEDICATIONS OR TREATMENT PLANS NEED TO BE ADMINISTERED/AVAILABLE AT SCHOOL?

☐ **Diabetic medications/Diabetic Care Plan** ☐ **EpiPen/Allergy/Anaphylaxis Care Plan** ☐ **Inhaler/ Asthma Care Plan**

☐ **Prescribed medications** ☐ **Seizure medications/Seizure Care Plan**

☐ **Other Treatments (describe)** _____

The ASD Nurse must be notified if any medications need to be given during the school day. State law requires written authorization from a health care provider and parent before any prescription medication can be given at school, including self-carry medication. All types of medication require an authorization/consent form AND the medication(s) must be delivered to the school by a parent/guardian in a pharmacy labeled container.

Please continue to the second page to complete this form

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Last Name	First Name	MI	DOB

PARENT / GUARDIAN CONSENT AND AUTHORIZATION

PERMISSION TO ACCESS STATE IMMUNIZATION REGISTRY

☐ **I CONSENT** ☐ **I DO NOT CONSENT**

…for the nurse to review my child's immunization information in the State of Alaska immunization registry (VacTrak).
The parent/guardian can remove permissions at any time by submitting your request in writing.

PARENT ACKNOWLEDGEMENT

My signature below is acknowledgement that the information provided is current and correct. I have reviewed the health history form and understand that it is my responsibility to notify the school when my child's health information has changed. I agree to provide any medications or supplies needed for care of my child in school if needed. I will notify the school if my consent for the above items needs to be updated or changed, per my preference.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

MEDICAL PROVIDER / PEDIATRIC GROUP: _____Phone_____

OTHER PROVIDER: _____ Phone_____