

**Dupo Community School District #196**  
**Health History Form 2018-2019**

**Name/Date of Birth** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Date** \_\_\_\_\_

**Previous Schools & City/State (New and Former Dupo Students):** \_\_\_\_\_

In order to provide optimum care of your child during school hours, we would like to be aware of any medical conditions your child may have. Please answer the following questions concerning his/her health regarding allergies, medications and action plans followed. Please notify your school nurse if any special needs are required during school hours. Most special needs will require a doctor's note. If you have already notified us of your child's health condition, an update would be appreciated.

**Doctor's name and phone number:** \_\_\_\_\_

**Hospital Preferred:** \_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_

**Food Allergies:** \_\_\_\_\_

**Environmental Allergies or Bee Sting Allergies:** \_\_\_\_\_

**Medications:** Please list any medications taken daily (prescription or over the counter). Dose of medication and how often it is taken is also helpful. This is important information in the event an emergency and an ambulance would need to be called.

\_\_\_\_\_  
\_\_\_\_\_

**Medical Problems: Please detail as much as possible; use the back side if necessary**

**Asthma:** How often is inhaler used \_\_\_\_\_ Date of last Dr. visit for asthma \_\_\_\_\_

**Blood disorders:** \_\_\_\_\_

**Concussions:** How many \_\_\_\_\_ Seen by a doctor? \_\_\_\_\_ Date of last one \_\_\_\_\_

**Seizure Disorder:** Type and Date of last seizure \_\_\_\_\_

**Autism/Aspergers:** Special routine or schedule? \_\_\_\_\_

**ADD/ADHD:** Date diagnosed by doctor \_\_\_\_\_ Medications at home, at school or both.

**Diabetes:** Oral medications/ Shots/ Insulin pump \_\_\_\_\_ Doctors orders for school? \_\_\_\_\_

**Mental Health (Depression/Anxiety/Bipolar.....):** Taking medications? \_\_\_\_\_ In counseling? \_\_\_\_\_

**Heart Conditions:** Type \_\_\_\_\_ Under Dr. care? \_\_\_\_\_

**Eyes:** Do you wear glasses/ contacts? \_\_\_\_\_ Date of last eye doctor exam \_\_\_\_\_

**Ears:** Do you wear hearing aids? \_\_\_\_\_ Date of last exam with a doctor \_\_\_\_\_

**Other conditions (not listed above)** \_\_\_\_\_

In the event of illness or minor injury please give name and number of contact person(s).

- 1.
- 2.
- 3.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

Your signature above provides consent for verbal or written communication between the school nurse and your doctor to provide optimal care for your child while at school.