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.