



Confidential Student Health History Update and Consent Form

Student Information (Optional)		
Last Name: _____ First Name: _____ Middle Name: _____	Date of Birth: _____ Current Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Grade: _____ (/ SY) Today's Date: _____	Home Phone: _____ Cell Phone: _____	Parent/Guardian (Person Completing Form): _____ _____

Student Health History (Optional)	
Questions: Does your child have or have they recently had any of the following?	If yes, please explain:
<i>An ongoing Medical condition?</i>	
<i>Seen a medical specialist in the past few years?</i>	
<i>Allergies specifically to:</i> <i>(See My Allergies Section Below for More Info)</i>	<input type="checkbox"/> Food <input type="checkbox"/> Grass <input type="checkbox"/> Insects <input type="checkbox"/> Dust <input type="checkbox"/> Medication <input type="checkbox"/> Mold <input type="checkbox"/> Other: _____
<i>Please provide month and year for any of the following that apply.</i>	
<i>Been hospitalized</i>	
<i>Had an operation</i>	
<i>Had an emergency injury needing treatment</i>	

<i>Broken bone, muscle sprain/strain/tear</i>	
<i>Seizure or Convulsion</i>	
<i>Passing Out or Head Injuries</i>	
<i>Special Dietary Needs</i>	
<i>Had a Vision problem or condition</i>	
<i>Had a Hearing problem or condition</i>	
<i>Braces, mouthpiece, or major dental work</i>	
<i>Asthma or Inhaler use</i>	If yes, provide instructions for asthma condition and materials are needed:

Current Medications Used (Optional)			
Medication Name	Dose/Dosage Prescribed	Time Given	Special Instructions

I ALLOW SCHOOL PERSONNEL TO GIVE MY CHILD MEDICATIONS THAT I HAVE SUPPLIED. Y N

I ALLOW SCHOOL PERSONNEL TO GIVE MEDICAL CARE/FIRST AID AND TO CALL 911, IF NEEDED. Y N

I ALLOW SCHOOL PERSONNEL TO GIVE OVER THE COUNTER MEDICATIONS SUCH AS (please check):

- TYLENOL IBUPROFEN BENADRYL (ALLERGY) COMMON COLD/COUGH MEDICINE
- 1st aid OINTMENT EYE WASH AMBESOL FOR TOOTH PAIN
- SALTWATER GARGLE OR NOSE SPRAY

*** ** GIVEN AS A 1 DAY COURTESY DOSE****SCHOOL WILL NOTIFY ME BY NOTE OR CALL. *****

- I WILL SUPPLY ANY FURTHER “OVER THE COUNTER” MEDICATION, WITH INSTRUCTIONS, THAT MY CHILD MAY NEED. THIS WILL BE TURNED INTO THE FRONT OFFICE.**

- I DO NOT WANT ANY “OVER THE COUNTER MEDICATIONS” GIVEN TO MY CHILD.**

Are your child’s immunizations/exemptions up to date?

YES **NO**

Immunizations/exemptions must be current by the first day of school attendance. Please see the list of required immunizations and schedules on the Arizona Department of Health Services website or call (602) 263-8856 for requirements and free clinic hours.

Student Immunization Information

I certify that the information above and all health-related information is correct, current and complete.

PARENT/GUARDIAN (PRINT) _____ SIGNATURE _____
DATE _____

Allergies

Student First, Middle and Last Name	
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Food Allergies *Please write none if there are no allergies	
Allergic To:	Medication Prescribed:

Natural Seasonal Allergies *Please write none if there are no allergies	
Allergic To:	Medication Prescribed:

Other Allergies *Please write none if there are no allergies	
Allergic To:	Medication Prescribed:

Parent Signature: _____

Date: _____