

# Health History

School Year \_\_\_\_\_

Name		Date of Birth	
Gender	School	Grade/Teacher	
Physician		Dentist	

The school district considers this to be personal, confidential information that will be treated in a discreet manner. The form may be reviewed by the school nurse, the classroom teacher, the building administrator, and other educators on a need to know basis.

**INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTH CARE PROVIDER WITH ANY OF THE FOLLOWING:**

Health Condition	Yes	No	Explanation if "Yes"
<b>Allergies</b> Bee Stings <input type="checkbox"/> Food Allergies <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Does your child require an EpiPen?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>List:</b> EpiPen? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>List:</b> EpiPen? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ADD/ADHD</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Medication:</b>
<b>Asthma</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Asthma medication taken at home:</b> <b>Medication required at school:</b>
<b>Autism Spectrum Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Describe:</b> Verbal <input type="checkbox"/> Non Verbal <input type="checkbox"/> <b>Medications:</b>
<b>Bowel/Bladder Issues</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Describe:</b>
<b>Diabetes</b>	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 (insulin dependent) <input type="checkbox"/> Type 2 <input type="checkbox"/> <b>Diabetes medications:</b>
<b>Hearing Loss</b>	<input type="checkbox"/>	<input type="checkbox"/>	Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> <b>Hearing Aids</b> <input type="checkbox"/>
<b>Heart Condition</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Describe:</b>
<b>Mental Health/Emotional/Behavioral</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Describe:</b> <b>Medication/Treatment:</b>
<b>Seizure Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Type of Seizure:</b> <b>Medications:</b>
<b>Serious Injury</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Describe:</b> <b>Dates:</b>
<b>Surgery</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Describe:</b> <b>Dates:</b>
<b>Vision</b>	<input type="checkbox"/>	<input type="checkbox"/>	Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> For Distance <input type="checkbox"/> For Reading <input type="checkbox"/>

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Other	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Please list medications taken at Home if not already listed:			
Medication			Dose                      How often                      Reason

**Medications**

Helena School District requires written permission from a Health Care Provider and parent/guardian before prescription or over-the-counter medication can be given to students K-8 grades at school. For High School students written permission from a Health Care Provider and parent/guardian must be provided for administration of prescription medications only. School Nurses **do not** have over-the-counter medications (Tylenol, Ibuprofen, Tums) to give to students. An *Authorization for Medications to be Given at School* form is available from your School Nurse or from the Helena School District website <https://helenaschools.org/departments/health-services/>

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Parent/Guardian Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

**imMTrax Consent Form for Children**



Child's Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_