



STUDENT HEALTH HISTORY FORM

District Nurse: 262.367.3606 x129

This form shall be completed by the parent/guardian of any child that is enrolled at or applying to Lake Country School. Please return this form when registering your child. Any information given will be treated confidentially. **Return this form to the school office.**

Date: _____

Student's First Name _____

Student's Last Name _____

Student's Date of Birth _____

Health History (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Bowel/Bladder Issue | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hearing/Vision Issue | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Mental Health Concern | <input type="checkbox"/> _____ |

If you checked that your child has a health history, please explain. Our school nurse will contact you for additional information if needed. Also include any medical history that we should be aware of in the event of an emergency.

ALLERGIES:

Does your child have allergies? Yes No Allergic to: _____

Date of last reaction: _____ Is Epi-Pen prescribed for allergy? *Allergic Reaction Plan Needed* Yes No

What happened? _____

MEDICATIONS:

Is your child currently taking any medication(s) at home? Yes No

No

Name of medication(s): _____

Will your child need any medication(s) at school? *Medication Authorization Form Needed* Yes No

Name of medication(s): _____

IS THERE ANYTHING MORE ABOUT YOUR CHILD THAT IS IMPORTANT FOR US TO KNOW?

X

Parent/Guardian Signature

Date