McPherson County School Health Services
PreK-12 NEW STUDENT HEALTH HISTORY

*It is important that the questionnaire be completed if student is **new/transferring to this school**. This information will be held confidential.*

Student _____Sex _____ Birth Date _____

Mailing Address _____ City _____ Zip_____ Grade ___

HEALTH HISTORY: (Check any that apply)

☐ Vision Problem
( ) glasses ( ) contacts ( ) reading glasses
☐ Hearing ( ) tubes ( ) hearing aids
☐ Frequent Ear Infections
☐ Allergies/Hay Fever
☐ Anemia
☐ Anxiety
☐ Asthma
☐ High Blood Pressure
☐ Muscle/Bone
☐ Bowel/Stomach
☐ Dental
☐ Depression
☐ Diabetes
☐ Eczema/Psoriasis
☐ Fainting Spells
☐ Heart
☐ Migraine Headaches
☐ Birth Defects
☐ Nosebleeds
☐ Seizure Activity
☐ Spine
☐ Surgery/Hospitalizations
☐ Urinary/Kidney
☐ Chickenpox
☐ Attention Deficit
Other (Please list)_____

Please explain any of the above health concerns: _____
_____

Restrictions: Diet _____ Activity _____

CURRENT MEDICATIONS: Include dosage, time taken and why taken _____
_____ _____ _____

_____ _____ _____

If medication will be taken during school hours, the **Request to Medicate Form** must be completed by the family physician and parent/guardian **before** medication can be dispensed at school.

ALLERGIES: (food, medication, bee stings, insects, etc.)

Emergency procedure/medication for allergic reaction _____

STUDENT'S DOCTORS:

Medical Doctor _____ Last Seen _____ Results _____
Dentist _____ Last Seen _____ Results _____
Eye Doctor _____ Last Seen _____ Results _____

An immunization record is required for each student and should be provided by a parent/guardian or last school attended. In addition, please provide proof of any recent immunizations to update the student's record.
I give consent for information about my student's immunizations to be released to the Kansas Immunization Program,
_____County Health Department (where immunizations are received),

_____(Health Provider/Physician, where immunizations received)
for the purpose of assessment and reporting. I understand that this authorization will expire when the student is no longer enrolled in the above-named district and that I may revoke this authorization in writing at any time.
☐ *I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises.*

_____ _____
Parent/Guardian Signature **Date**

☐ Yes ☐ No Request conference with the school nurse

4/10