

Crescent Elementary School
Health History, Medication, and Allergy Information
To be filled out by parent/guardian

Student Name _____ **Date of Birth** _____ **Grade** _____
Parent/Guardian Name _____
Place of Birth _____ Birth weight _____ Prematurity _____
Problems during pregnancy, labor, delivery or infancy _____

Physician _____ Phone # _____

Health Conditions: Please check all that apply to your child:

ADD/ADHD	diabetes	mononucleosis
allergies	eating disorder	musculoskeletal disorder
allergy life threatening	endocrine disease	nosebleeds
asthma/reactive airway disease	ear infections/tubes	orthodontic appliance
behavioral/ emotional / psychological	fracture / broken bone	pneumonia
blood disorder	fainting / dizziness	prosthesis
bowel difficulty	genetic disorder	seizure disorder
brain / CNS disorder	headaches	skin disease
cancer	hearing disorder	urinary / kidney disease
cerebral palsy	hospitalizations	visual impairment
concussion / head injury	hepatitis	glasses / contacts
cystic fibrosis	low blood sugar	other _____
developmental delay	surgeries	

Please fully explain any answers checked above (include severity and symptoms of allergies, to include medications). List all hospitalizations and surgeries. _____

Allergies: Please list type of allergy, reaction, and medication, if any, required.

Medication allergy: _____

Food allergy: _____

Other Allergies: _____

Medications: Please list any medication your child takes on a regular basis. _____

Please list any other health concerns that the school nurse or your child's teacher should know which might affect the student's school experience: _____

Unless you provide the School Nurse with a valid waiver, in the event of an emergency, if you can not be reached, and we believe it necessary for the physical well-being of the student, we will consult with the physician listed above, or if that physician cannot be reached, another physician chosen by the School Nurse or Administrator. We will also transport the student by ambulance to the nearest hospital if deemed necessary by the physician or school personnel.

Parent Signature

Date