ROSEMEAD HIGH SCHOOL
STUDENT HEALTH HISTORY

STUDENT'S NAME: _____ *DATE OF BIRTH:* _____ *GRADE:* ____

PARENT/GUARDIAN: _____ *TELEPHONE #:* _____

Please fill in all current information that the School Nurse should know:

1. *Does your child take any medication regularly? Yes ___ No ___*
   If yes, name of medication: _____ *Frequency:* _____

2. *Has your child ever been stung by a bee/hornet? Yes ___ No ___*
   If yes, is your child allergic to stings? Yes ___ No ___
   If yes, did your child have trouble breathing? Yes ___ No ___
   Did your child develop a rash? Yes ___ No ___

3. *Is your child:*
   Allergic to grass/pollens requiring medication/treatment: Yes ___ No ___
   If yes, what treatment is required: _____
   Allergic to any medication? Yes ___ No ___ If yes, name of medication: _____
   Allergic to certain foods or substances: Yes ___ No ___ If yes, name: _____
   *Has **EPIPEN** ever been prescribed? Yes ___ No ___*

4. *Does your child have **ASTHMA**? Yes ___ No ___*
   If yes, do they take medication or use an inhaler? Yes ___ No ___
   How often is the medication/inhaler used? More than once a week ___ 2-3 times a month ___ 1-6 times a year ___
   My child is under care for this condition by Dr. _____ *Telephone #:* _____

5. *Has your child ever had the **CHICKENPOX**? Yes ___ When?* _____ *No ___*
   Has your child had the VARIVAX vaccine for CHICKENPOX? Yes ___ When? _____ *No ___*

6. *Does your child wear glasses? Yes ___ No ___ Contact lenses? Yes ___ No ___*
   If yes, are glasses for: Distance ___ Reading ___ To be worn at all times ___
   Does your child have a hearing problem? Yes ___ No ___
   Right ___ Left ___ Both ears ___ Wears a hearing aid? Yes ___ No ___

7. *Does your child have any special needs due to the following?*
   Dental ___ Diabetes ___ Earaches ___ Epilepsy___ Special Diet ___
   Fainting Spells ___ Heart Problems ___ Hernia ___ Hyperactivity ___ Stomach Aches ___
   Learning Difficulties ___ Nosebleeds ___ Orthopedic ___ Seizures ___
   Limited Physical Education for the following reasons: _____
   _____

8. *Has your child ever been enrolled in any of the following programs?*
   Speech _____ *R.S.P.*_____ *Special Day Class* _____ *Adapted P.E.* _____

9. *Has your child ever been hospitalized because of an illness or accident?*
   Yes ___ No ___ If yes, explain _____

10. *Name any other health condition that the school nurse should be aware of:*
    _____

11. *Date of last Physical Examination:* _____ *Doctor's Name:* _____

12. *Does your child have Health Insurance? Yes ___ No ____ Name of Insurance Company:* _____

I give permission for the School Nurse to share this information with school staff when necessary for my child's well-being

Parent's Signature: _____ *Date:* _____

ROSEMEAD HIGH SCHOOL
INFORMACION DE SALUD DEL ESTUDIANTE

Nombre del Estudiante: _____ *Fecha de Nacimiento:* _____ *Grado:* _____

Nombre de la Madre/Padre/Guardian: _____ *Telefono:* _____

Cambios en la condicion de salud: Por favor llene informacion actual que su enfermer escolar debe de tener:

1. *Toma su hijo/a medicina regularmente? Si ___ No ___*
   Si la repuestas es si, cual es el nombre de la medicina? _____

2. *Alguna vez la ha picado a su hijo/a una avispa o abeja? Si ___ No ___*
   Tuvo Alergia a la picadura? Si ___ No ___
   Si la repuesta es si, tuvo dificltades para respirar? _____
   Le salieron ronchas o alguna erupcion en la piel? _____

3. *Es su hijo/a:*
   Alergico/a al cesped (zacate)/pollen? Si ___ No ___
   Si la respesta es si, cual es el tratamiento necesario? _____
   Alergico/a a alguna medicina? Si ___ No ___
   Si la respuesta es si, cual es el nombre de la medicina? _____
   Alergico/a ciertas omidas o a atras substancias? Si ___ No ___
   Si la respuesta es si, a que comidas o substancias? _____
   *Le han recetado **EPIPEN**? Si ___ No ___*

4. *Sufre el/ella de **ASTHMA**? Si ___ No ___*
   Nombre de la medicina/inhalador _____
   Que tan refquentemente toma la medicina/usa el inhalader?___ Mas de una vez por seman? ____
   2 a 3 veces por mes ____ 1 a 6 veses al ano ____
   Mi hijo/a esta bajo tratamiento medico por esta condicion con el doctor: _____
   Telefono: _____

5. *Ha tenido alguna vez su hijo/a VARICELA locas? Si ___ No ___ Cuando?* _____
   Vacuna Varivax? Si ___ No ___ Cuando? _____

6. *Usa el/ella antejos o lentes de contacto? Si ___ No ___*
   Son los lentes par aver de lejos? ___ Solamenta para leer? ____ Para usarlos constantemente? ____
   Tiene e/ella problemas auditivos (de oido) Si ___ No ___
   Oido derecho? ____ Oido izquierdo? ____ Ambos oidos? ____ Usa auxillares auditivos? ____

7. *Tiene su nino/a alguna necesidad especial por alguno de los siguientes problemas?*
   Dental ____ Diabetes ____ Dolores de oidos ____ Epilepsia ____ Desmayos ____ Corazon ____
   Ortopedicos ____ Ataques ____ Dieta Especial ____ Dolores de estomago ____
   Educacion fisica limitada por las siguientes reones: _____

8. *Ha estado su nino/a alguna vez matriculado en alguno de los siguientes programas?*
   Lenguaje/habla ____ Recursos Especiales (RSP) ____ Clase Especial ____ Educacion Fisica Adaptada ____

9. *Ha sido su nino/a hospitalizado por mas de una noche por enfermedad o accidente? Si ____ No ____*
   Escriba el motive _____

10. *Describa cualquier otra condicion medica la cual nosotros deberiamos de saber* _____

11. *Fecha en que tuvo el ultimo examen medica* _____ *Nombre del medico* _____
12. *Tiene su nino/a tiene seguro medico? Si ____ No ____ Nombre de seguro* _____

Doy autorizacion a la enfermera escolar, para que comparta esta informacion con el personal de la escuela cuando esto sea necesario para el cuidado/bienestar de mi nino/a

Firma del Padre/Madre: _____ *Fecha:* _____

SCHOOL MEDICATION AUTHORIZATION FORM

Name of Child _____ Date of birth: _____

School _____ Phone: _____ FAX # _____

California Ed Code 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school or maintain or improve the potential for education and learning.

Medication must be in the container in which it was purchased with a pharmacy label attached. No medication (including over-the-counter medication and supplements) will be given at school without a current prescription from a California licensed physician.

PHYSICIAN'S ORDER *(To be completed by health care provider)* ***Only one medication per form***

Name of medication/strength of tablet, capsule or liquid _____

This medication is a controlled substance ☐ Yes ☐ No

Dosage: _____ How Often? _____

Time to be given at school: _____ Route to be given: _____

Reason for medication/Diagnosis: _____

Possible side effects: _____

☐ Student has been instructed by physician in self-administration and may carry the inhaler with them

☐ Student has been instructed by physician in self-administration and may carry the Epi-Pen with them

Comments _____

_____

It is necessary for this medication to be taken during the school day at the time(s) indicated above.

_____ _____

Print Name of Licensed Physician Signature of Licensed Physician

_____ _____ _____ _____

Address Phone Date License #

****

TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider.

I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request.

_____ _____ _____

Parent/Guardian Signature Date Phone (home)

_____

Phone (emergency)

Name of medication to be given at school _____ **Time to be given at school** _____

Form must be renewed every 12 months or whenever the prescription changes.

dh 8/15/2006