STUDENT HEALTH HISTORY (please print) **RIVER VIEW LOCAL SCHOOLS**

STUDENT'S LAST NAME ______ FIRST ______ MI ______ SEX ______ DATE OF BIRTH ______

DATE OF LAST PHYSICAL EXAM:______by Dr.______ **DATE OF LAST DENTAL EXAM:**______by Dr.______

I. STUDENT HEALTH CONDITIONS:

☐ **NO medical conditions** ☐ **YES, child has the following conditions**:

____Abnormal spinal curvature (scoliosis, etc.)
____Allergies or hay fever (list below in section III)
____Asthma
____ADD/ADHD
____Autism
____Behavior concerns
____Birth or congenital malformation
____Bone/muscle/joint problems
____Blood problems
____Bowel/bladder problems
____Cancer, Type________________
____Cystic Fibrosis
____Depression
____Diabetes
____Ear problem/hearing difficulty
____Emotional Concerns
____Headaches (frequent)
____Heart Problems
____Hemophilia
____Hepatitis
____Juvenile arthritis
____Lead Poisoning
____Menstrual problems
____Neuromuscular disorder
____Seizure disorder
____Sickle Cell disease
____Skin conditions
____Speech problems
____Traumatic brain injury
____Vision problems (glasses, contacts)
____Other________________________
____Other________________________
____Other________________________

Please explain any conditions above or any reasons for hospitalizations:

II. VISION AND HEARING

When was last eye exam done by eye doctor? (approximate date or "never")__________________________ Wears glasses/contacts ____?

Please answer Yes or No: _____Frequent ear infections? _____If yes, were tubes placed? _____ Are tubes still in place? _____ Is there a hearing loss?

III. Allergies Please indicates any allergies child may have. ☐ **NO KNOWN ALLERGIES** **NOTE: Special Forms Required for Medications that must be administered at school.**

Allergy type	Reaction	Treatment/Recommended Actions/School Restrictions
☐ Bee/Insect (type)		
☐ Food (list)		
☐ Medication (name)		
☐ Other (list)		

IV. MEDICATIONS Please list any prescription and over the counter medications that child takes on a regular basis NOTE: **Special Forms Required for Medications that must be administered at school.**

Medication and dose	Time	Reason

V: Do any health and/or medical conditions require school restriction, modifications, and/or intervention? ☐ Yes ☐ No If YES, please explain.

____

VI: Does the student require any special procedures and or treatments for their health condition? ☐ Yes ☐ No If YES, please explain.

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VII: Please indicate any other information about child's health or development that you think would be helpful for the school to know.

FORM COMPLETED BY:______________________ RELATIONSHIP TO STUDENT:______________________ DATE:__________

- THIS INFORMATION WILL BE KEPT IN STUDENT'S HEALTH RECORD.

ADDITIONAL COMENTS OR OTHER CONCERNS ABOUT STUDENT'S HEALTH ON BACK, IF NEEDED. 5/2015