Anchorage School District

HEALTH HISTORY FORM

PLEASE COMPLETE FOR ALL NEW-TO-DISTRICT, PRESCHOOL, KINDERGARTEN, 5TH, AND 9TH GRADE STUDENTS
OR AS NEEDED FOR OTHER GRADES TO UPDATE NEW / EXISTING HEALTH CONCERNS

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

MEDICAL HISTORY

☐ YES ☐ NO **Does your child have any health concerns?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have restrictions to participate in any activities?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have any allergies?**
If yes, please list allergies: _____
What does the allergic reaction look like? _____

☐ YES ☐ NO **Is your child prescribed an Epi-Pen?**

☐ YES ☐ NO **Does your child have asthma?**
If yes, please describe type or triggers: _____

☐ YES ☐ NO **Does your child have diabetes?**

☐ YES ☐ NO Is your child prescribed medication for diabetes management? *If yes, please list medication, dose, and time below

☐ YES ☐ NO **Does your child have a heart condition?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have a bleeding disorder?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have an orthopedic condition?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have a history of seizures or another type of neurological disorder?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have any gastrointestinal concerns or issues with eating?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have any bowel or bladder concerns?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have behavioral, emotional, or mental health concerns?**
If yes, please describe: _____

☐ YES ☐ NO **Does your child have any vision concerns?** ☐ **GLASSES** ☐ Other: _____

☐ YES ☐ NO **Does your child have any hearing concerns?** ☐ **HEARING AID** ☐ Other: _____

☐ YES ☐ NO **Does your child currently take medications?**
If yes, please list: _____

DO ANY PRESCRIBED MEDICATIONS NEED TO BE ADMINISTERED OR AVAILABLE AT SCHOOL?

☐ **Epi-Pen** ☐ **Albuterol inhaler** ☐ **Seizure medications** ☐ **Diabetic medications** ☐ **Prescribed medications**

Medication: _____ Dosage: _____ Times Given: _____
Medication: _____ Dosage: _____ Times Given: _____
Medication: _____ Dosage: _____ Times Given: _____

The ASD Nurse must be notified if any medications need to be given during the school day. State law requires written authorization from a health care provider and parent before any prescription medication can be given at school, including self-carry medication. All types of medication require an authorization/consent form AND the medication(s) must be delivered to the school by a parent/guardian in a pharmacy labeled container. Homeopathic and herbal remedies cannot be given at school.

Please continue to the second page to complete this form. ➡

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MY CHILD WILL REQUIRE THE FOLLOWING PLAN OR OTHER TREATMENT AT SCHOOL (check all that apply)

- ☐ **Allergy Action Plan**
- ☐ **Asthma Action Plan**
- ☐ **Seizure Action Plan**
- ☐ **Diabetic Care Plan**
- ☐ **Other treatment required** (explain below)
- ☐ **None**

MEDICAL PROVIDER / PEDIATRIC GROUP: _____

DENTAL PROVIDER: _____

PARENT / GUARDIAN CONSENT AND AUTHORIZATION

PERMISSION TO ACCESS IMMUNIZATION RECORDS

☐ **I CONSENT** ☐ **I DO NOT CONSENT**

…for the nurse to review and enter immunizations administered by the Anchorage School District in the State of Alaska immunization registry (VacTrak), managed by the Epidemiology Section of the Alaska Department of Health and Social Services. You can remove permissions at any time by submitting your request in writing.

PERMISSION TO RELEASE AND/OR EXCHANGE MEDICAL INFORMATION WITH SCHOOL STAFF

☐ **I CONSENT** ☐ **I DO NOT CONSENT**

…for the school nurse to share health information with school staff on a need-to-know basis. The school staff will be informed of medical needs, safety precautions, and procedures necessary to protect your child while at school. It is the responsibility of the parent/guardian to notify the school nurse of any changes or updates in your child's health history.

PARENT ACKNOWLEDGEMENT

My signature below is acknowledgement that the information provided is current and correct. I have reviewed the health history form and understand that it is my responsibility to notify the school when my child's health information has changed. I will notify the school if my consent for the above items needs to be updated or changed, per my preference.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER

PARENT / GUARDIAN (SIGNATURE)	DATE