****

**Student Health History Form**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name:First Last Middle

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Local Address

DOB (mm/dd/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_ Gender: M F

Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFORMATION: (PLEASE LIST WHO CAN ASSIST IN CASE OF EMERGENCY)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name#1 Relationship Home Phone Cell Phone*

Can pick up in emergency? YES\_\_\_ NO\_\_\_ Can share emergency information? YES\_\_\_ NO\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name#2 Relationship Home Phone Cell Phone*

Can pick up in emergency? YES\_\_\_ NO\_\_\_ Can share emergency information? YES\_\_\_ NO\_\_\_

Local Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit:\_\_\_\_\_\_\_\_\_\_\_

**Please indicate any allergies your child may have.**

***Allergy Type* *Reaction* *School Restrictions***

|  |  |  |
| --- | --- | --- |
| * Bee/Insect |  |  |
| * Food |  |  |
| * Medication |  |  |
| * Other |  |  |

**Student Health Conditions**

* **YES,** my child receives regular medical/health care for the following conditions:
* **NO ,** there are nomedical conditions of concern

|  |  |  |
| --- | --- | --- |
| * Allergies\*\*See below * Asthma \*\*See below * ADD/ADHD * Autism * Behavior concerns * Birth/congenital defect * Bone/muscle/joint * Blood problems * Bowel/bladder problems * Cancer * Cystic Fibrosis | * Diabetes * Depression * Ear/hearing difficulty * Emotional concerns * Headaches * Heart problems * Hemophilia * Juvenile arthritis * Lead poisoning * Migraines * Neuromuscular disorder | * Seizure disorder * Sickle cell anemia * Skin conditions * Speech problems * Traumatic brain injury * Vision problems (glasses, contacts) * Other\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please explain any conditions above or any reasons for hospitalizations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*If your child has required medication and/or treatment for asthma/allergies, an action plan is required to be written and implemented. Please attach to this form.**

Is your child currently under medical treatment? If so please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription and over the counter medications that your child takes on a regular basis.

|  |  |  |
| --- | --- | --- |
| **Medication and Dose**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Time**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Reason**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention? If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is the policy of St. Kitts International Academy, that we can only administer over the counter medication brought in by a parent. **Medication must be in its original sealed bottle and labeled with child’s first and last name.**  A written note by parent must accompany medication stating what the medication may be given for if deemed necessary by school personnel.

**Consent for Treatment**

In the event that reasonable attempts to contact me have been unsuccessful; I HEREBY GIVE MY CONSENT for: 1.) the administration of any treatment deemed necessary by the physician above or in the event the designated preferred practitioner is not available, by another licensed practitioner; and 2.) the transfer of my child to the hospital. I accept full financial responsibility for the payments of all charges made for medical services rendered. I absolve school officials of any liability who in good faith complies with this request.

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_**

**Refusal of Consent**

I DO NOT give my consent for treatment of my child.

\*Note that in ***life threatening*** situations emergency care will be provided until a parent arrives on the scene.

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_**