Fort Bend I.S.D. Health Services Department
Health History Form

Your student's health history will help us assess any physical conditions which may require adjusting his/her school program. This information will become a part of your student's school health record and remains confidential. Please complete **both sides** of this form and return it to the school nurse.

Students Name:	**Date of Birth:**	**Grade:**
Parents Name:	**Home Phone:**	**Cell Phone:**
Doctors Name:	**Doctors Phone:**	**Doctors Fax:**

1. **Has your student ever attended a Fort Bend I.S.D. school?** Yes / No **Name of last school attended:_____ Grade:_____**

2. **Has your student had chickenpox?** Yes / No **Date of infection: _____ (include month and year)**

I _____ (parent/guardian's name) certify that _____ (student's name) has had chickenpox and does not need the Varicella vaccine.

Allergies

Does your student have allergies to medications?	**Yes**	**No**
Please list:		
Treatment required:		
Does your student have any other allergies?	**Yes**	**No**
Please list:		
Treatment required:		

Reaction to Insect Bites/Stings

Does your student have serious reaction to insect bites?		**Yes**	**No**
Please list type of insect (for example fire ants):			
What type of reaction occurs?			
Swelling around bite area only yes / no	**Itching** yes / no	**Hives** yes / no	
Swelling of lips and/or eyelids yes / no	**Difficulty breathing** yes / no	**Other:**	
Does your student require special treatment? yes / no			
What type of treatment? (Note: If immediate treatment for insect stings is required, medication and allergy action plan will be required.)			

Has your student experienced any of the following health conditions?

	Yes	**No**
Asthma		
Seizure Disorder		
Frequent Fainting		
Heart Trouble		
Blood Pressure Problems		
Bowel or Bladder Problems		
Bone or Muscle Problems		
Blood Disorders		
Diabetes		
Headaches		
Hyperactive Behavior and/or Attention Deficit Disorder		
Emotional Problems		
Vision or Eye Problems		
Hearing Problems or Ear Disease		
Speech Problems		
Dental Problems		
Premature Birth or Traumatic Birth		
Severe Injuries		
Operations or other hospitalizations		
Positive Skin Test to Tuberculosis		
Active Tuberculosis		
Other Medical History not yet asked		

If you answered yes to any of the above questions listed under the health conditions section, please explain the type of problem, the age of onset, and the treatment required in the area provided below.

Type of Problem	Age of Onset	Treatment Required

Does your student have any physical restrictions? yes / no

If yes, please explain the restriction and indicate the need for assistance while in the school setting. (Physician's note needed for long-term modifications).

Does your student take any medications routinely either at home or at school? Yes / no

Name of Medication	Dosage	Time(s) Given	Purpose of Medication	Will it be taken at school?	
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**
				Yes	**No**

Pertinent information may be shared with appropriate personnel.

_____ _____

Parent/Guardian Signature Date