Pleasant Valley School, District #27
Student Health History Form
School Year: _____ - _____

Student's Name: _____
Birth date: _____ / _____ / _____ Male ___ Female ___
Grade: _____

The following information is **confidential**. Parents/guardians are required to complete **a new form each school year** or if new medical information is updated.

PERMISSION TO GIVE NON-PRESCRIPTION MEDICATION AT SCHOOL

My child may receive medications in my absence that I checked below from the lead teacher (dosed according to the medication label only. Medications listed are provided in limited supply from the school and are used sparingly).

- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Antacids (Tums/Mylanta)
- ☐ Cough drops
- ☐ Diphenhydrime (generic Benadryl)
- ☐ Sun screen
- ☐ Topicals (includes antibiotic ointment, hydrocortisone, anti-itch cream, Vaseline, Carmex/Blistex, hand/body lotion, Saline, Caladryl/Calamine lotion, Sting kill (Benzocaine), sunburn relief lotion (may contain aloe and/or lidocaine)

Comments: _____
_____

DAILY MEDICATIONS

Does your child take daily medications? ☐ No ☐ Yes (If yes, please list current medications)

Name of Medication	Dose	Route (oral, drops, inj.)	Time given	Reason given

Does your child require medication to be given at school? ☐ No ☐ Yes (If yes, please contact the lead teacher)

- All prescription medication to be given at school require a medical order from your child's physician for school.
- Only parents/guardians are allowed to bring medication to school. Do not send with your child. See the student handbook or school policy manual for rules/regulations regarding medication at school.

MEDICAL HISTORY

Does your child have any of the following conditions? (Check all that apply, please explain in the box below) ☐ **None**

☐ ASD (Autism)	☐ Cancer	☐ Genetic/Congenital	☐ Migraines
☐ ADD/ADHD	☐ Diabetes	☐ Glasses/Contacts	☐ Pet Allergy
☐ Asthma	☐ Eating Disorder	☐ Heart Condition	☐ Sleep Disorder
☐ Blood disease	☐ Emotional concerns	☐ Head Injury/Concussion	☐ Seizures
☐ Bowel/Bladder	☐ Food Allergy/Intolerance	☐ Hearing Impaired	☐ Stomach – frequent

☐ Other
Comments/Concerns:

List any recent hospitalization or treatments and explain (please include dates):
_____
_____
_____

Don't forget to complete the back side of this form

ALLERGIES

Does your child have any significant allergies? (Include known food allergies) □ Yes □ No

- If yes, list allergy(s) and symptom(s) of allergic reaction: _____

_____

How is the allergy treated? _____

Does your child have EPI PEN, EPI JR or Auvi-Q prescribed to treat allergy? □ Yes □ No

(If yes, please contact the lead teacher before the first day of school to prepare an emergency action plan.)

MEDICAL PROCEDURES OR TREATMENTS REQUEST

Does your child have any special medical procedures or emergency treatments needed during school hours? □ Yes* □ No

*All medical procedures or treatments required at school must have a doctor's medical order on file with the lead teacher before any procedures/treatments can be performed. Please contact the lead teacher prior to the first day of school to discuss a specific request.

ACTIVITY RESTRICTIONS

Does your child have any restrictions for physical activities? □ Yes □ No

If yes, a written note from your physician for the current school year, stating the restrictions, is required and needs to be updated yearly.

IMMUNIZATIONS REQUIREMENTS

Make sure the district clerk has an up-to-date copy of your child's vaccine record. Immunization records, religious objections or medical exemptions are due to the school district clerk before the first day of school. Objections and exemptions must be resubmitted every school year. Any student who does not have the Montana State-required school immunizations* on file before the first day of school will be excluded until proof of vaccination is provided. Please consult the school district clerk if you have any questions or are registering/relocating to the district during the school year.

*See the Flathead County website for required vaccines by grade level.

EMERGENCY CARE

This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. In the case of an emergency, if the school is not able to contact me, I give permission to take the student to the nearest hospital or appropriate facility for medical attention. This medical information may be shared with school personnel, EMTs, and hospital personnel as needed. If it is necessary to contact an ambulance or life flight, it will be the responsibility of the parent/guardian to pay for this service. I understand a copy of this information will be sent with my child to the hospital. If I cannot be reached by telephone in the event of an emergency involving:

(Student's name) _____, please send my child to the □ nearest □ preferred hospital: _____ , or any available medical service. This information is current and correct. I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes in contact information. I understand that this health history form must be updated every school year.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____

Please specify preferred method of contact: (circle one) HOME PHONE / CELL PHONE / EMAIL

JR. KINDERGARTEN & KINDERGARTEN STUDENTS

A physical exam is highly recommended before the start of school. Please provide a copy of the exam and your child's immunization record to the school district clerk along with this form.

TO BE COMPLETED BY PLEASANT VALLEY SCHOOL STAFF ONLY

□ Allergy/Anaphylaxis Emergency Action Plan □ Asthma Action Plan □ Diabetes Care Plan

□ Seizure Action Plan □ Other treatments for school □ Health Care Plan needed