# Central York School District

**STUDENT HEALTH HISTORY**

To be completed by Parent/Guardian

**Student Name:_____Date of Birth:_____**

Last School Attended:_____(city)_____(state)_____

**Please check the EMERGENCY health conditions your child has:**
Asthma___ Diabetes___ Heart Condition___ Seizures___ Other___

Please provide details about your child's condition. Include any treatment they may need at school.

**Specify if your child has a LIFE-THREATENING ALLERGY to:**
Foods___ Latex___ Medications___ Stings___ Other___

Please list the specific allergy, typical reaction & treatment. When was your child's last reaction & was an epi-pen given?

**Please check the CHRONIC conditions your child has and list possible needs during the school day:**
Cerebral Palsy ___ Cystic Fibrosis ___ Sickle Cell Disease___ Spina Bifida___ Other___

**CURRENT MEDICATIONS**: Please include all medications your child is taking.

| Medication | Dose | Reason for Medication |
|---|---|---|
| | | |
| | | |
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**Please share any other health concerns about your child.** Please do not assume we already have the information. List more specific information & possible needs during the school day for all "YES" answers.

YES/NO ADD/ADHD_____

YES/NO Allergies (non-life-threatening):_____

YES/NO Hearing or Vision Problems:_____

YES/NO Migraines or Fainting:_____

YES/NO Nutrition/Special Dietary Need: _____

YES/NO Other Health Concerns:_____

**Please list the best emergency phone numbers to call during the school day:**

1.)_____

2.)_____

By signing below, I give permission to share information about my child's health with the adults responsible for my child's on-going safety at school.

Parent/Guardian Signature_____Date:_____