

**MONROE-GREGG SCHOOLS**  
**Personal Health History**

**Parent/Guardian: Please complete both sides**

Student \_\_\_\_\_  
 Home Phone \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
 Insurance Information  Private  Medicaid/Hoosier Healthwise  No Insurance  
 Mother/Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_  
 Father/ Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_  
 Cell Phone # \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Physician Name \_\_\_\_\_ Phone # \_\_\_\_\_

Complete the following checklist by indicating any of the following conditions, past or present. Include a separate sheet if additional detail is necessary.

	YES	NO	DATE		YES	NO	DATE
<input type="checkbox"/> Allergies, <input type="checkbox"/> Seasonal, <input type="checkbox"/> Animals <input type="checkbox"/> Other explain				<input type="checkbox"/> Hearing loss <input type="checkbox"/> Wearing hearing aids			
Bee/Insect Sting Allergy <input type="checkbox"/> Local reaction <input type="checkbox"/> Reaction requiring hospital <input type="checkbox"/> Requires an Epi Pen				<input type="checkbox"/> Heart Condition <input type="checkbox"/> Rheumatic Fever Murmur <input type="checkbox"/> infant <input type="checkbox"/> recent			
ADD/ADHD <input type="checkbox"/> Medication at home <input type="checkbox"/> Medication at school				Lead poisoning			
Anemia (type) _____				Lung Disease/TB			
Arthritis <input type="checkbox"/> Rheumatoid Other(explain) _____				Medication Allergy _____			
Asthma (give details) <input type="checkbox"/> Emergency Inhaler required				Nutrition/Eating Disorder (overweight/underweight)			
Back /Neck Injury or condition				Orthopedic/Bones			
Bladder/ Kidney problems				Psychological/Psychiatric <input type="checkbox"/> Medication list on back			
Blood /Clotting Disorder <input type="checkbox"/> Hemophilia <input type="checkbox"/> Other Explain				<input type="checkbox"/> Seizures from fever <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other			
Cancer/Leukemia				Surgery-type/ explain			
Diet Restrictions Explain below				Vision <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> Other			
Food Allergy/Intolerance <input type="checkbox"/> Life threatening / Epi Pen <input type="checkbox"/> Intolerance				Other (explain below) _____ _____			
Head Injury <input type="checkbox"/> Recent <input type="checkbox"/> Concussion <input type="checkbox"/> Other				<b>Childhood disease</b> <input type="checkbox"/> yes <input type="checkbox"/> No <b>Date of Chickenpox</b> <b>Disease</b> <input type="checkbox"/> Month <input type="checkbox"/> Year			
<input type="checkbox"/> Headaches <input type="checkbox"/> Migraine							

**CONTINUE AND COMPLETE THE OTHER SIDE OF THIS FORM**

Please give details for all that are marked **YES** on side one that may impact your child's routine at school

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Is this student under any ongoing medical/emotional care or treatment?  YES  NO Include physician's name.

Explain \_\_\_\_\_

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Does this student require daily medication in the form of a patch  YES  NO

Name of medication, dosage, reason, and frequency \_\_\_\_\_

Does this student take any medication (prescribed and /or over the counter (OTC)?  YES  NO

Explain? Include physician's name, dosage, reason and frequency:

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Most medications may be taken at home. Will this student be required by a physician to take medication \*\* during school hours?

YES  NO Explain: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Condition \_\_\_\_\_

Name of Medication \_\_\_\_\_ Condition \_\_\_\_\_

Name of Medication \_\_\_\_\_ Condition \_\_\_\_\_

Recent hospitalization/overnight Date \_\_\_\_\_ Condition \_\_\_\_\_

**NOTE\*\* ALL MEDICATION REQUIRES AN ADDITIONAL SIGNED MEDICATION PERMIT ON FILE PRIOR TO ADMINISTRATION AT SCHOOL.**

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. This will be done only on a "need to know" basis, in a confidential manner. I agree that the school nurse may consult with my child's family Physician (s) about the above medical condition (s). I agree to alert the school nurse and my child's teacher, in writing, of any Changes in medications, and/or health status of my child. I will furnish the school with a current telephone number and address In case of an emergency. The above permission will be valid through July 2010, unless I revoke the permission in writing.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Individual HealthCare Plans should be in place for student, with Asthma, Diabetes, Seizures, Food Allergies, Insect Sting Allergies, Cancer, Hemophilia and other health conditions. Many plans require doctor's signatures so contact your school nurse as soon as possible to complete the plans. Plans should be completed and in place before the first day school.**

PLEASE COMPLETE AND RETURN AT BOOK RENTAL ON AUGUST 4<sup>th</sup> OR 5<sup>th</sup> OR BEFORE THE FIRST DAY OF SCHOOL