ARLINGTON CENTRAL SCHOOL DISTRICT HEALTH HISTORY (To be completed by parent/guardian)

Student Name(Last, First, Middle Initial)	Sex Date of Birth/
I. <u>Life Threatening Allergic Conditions</u> : (Check all that apply.)	
Severe allergic reaction to Bee Stings, other insects: Severe reaction to Nuts, Peanuts: Severe reaction to other Food Products: Other severe allergies affecting school: Please indicate any of your child's symptoms which would indicate a severe allergreaction.) I ltching and/or tightness in the throat, hoarseness Shortness of breath, coughing, and/or wheezing Hives	gy: (Local swelling does <u>not</u> indicate a severe allergic ing or swelling of the eyes, lips, tongue or mouth
Has your physician prescribed an Epi-Pen or other medicine for a severe life threater Specify medication: strongly advised that he/she have this medication in school; it is required for int physician's order specifying that he/she is able to "self-administer" it. Carefully below.	* If you answered "Yes", it is terscholastic sports, (grades $7 - 12$), with a

II. Health Conditions: Has your child been diagnosed by a physician with any of the following? Check "Yes" or "No". Provide dates and details for all items checked "Yes".						
Yes	No	Condition	Details/Dates			
165	110	Attention deficit or ADHD	Details/Dates			
		Date diagnosed Meds: Yes No				
		Allergies to medications				
		Allergies (environmental or seasonal)				
		Asthma/Reactive Airway Uses an inhaler? Yes No				
		Uses a nebulizer? Yes No				
		If your child uses an inhaler, it may be advisable to have this medication in				
		school; it is <u>required</u> for interscholastic sports, (grades 7–12), with a physician's				
		order specifying that he/she is able to "self-administer" it. Carefully read the				
		MEDICATIONS IN SCHOOL section below.				
		Autism or Aspergers or PDD-NOS (not otherwise specified)				
		Behavior problem				
		Bleeding disorder				
		Bowel or digestive problem Cancer, Type:				
		Date diagnosed				
		Cerebral Palsy				
		Chromosomal disorder: Down's syndrome Other – specify →				
		Cleft lip/palate				
		Cystic Fibrosis				
		Dental problem				
		Depression				
		Diabetes: Date diagnosed Insulin Dependent: Yes No				
		Eating disorder:Anorexia Bulimia				
		Emotional disorder				
		Growth problems				
		Heart problem:MurmurHigh Blood PressureOther				
		EKGEchocardiogramStress Test Hepatitis, Type: Date diagnosed				
		Hernia Date diagnosed				
		High blood pressure				
		Hospitalizations:				
		Immunodeficiency disease				
		Kidney or urinary problem				
		Lyme disease				
		Muscular disorder				
	I					

Yes	No	Condition	Details/Dates			
		Migraine headaches				
		Nutritional/weight problem				
		Orthopedic problem (bone, joint)				
		Pregnancy				
		Rheumatoid Arthritis				
		Scoliosis/abnormal spinal curve: Date of diagnosis				
		Date of last evaluation				
		Seizure disorder, Type				
		Date of last seizure:				
		Meds: Yes No Medication				
		(Please provide physician documentation of diagnosis.)				
		Self-Harm/Mutilation				
		Sickle cell disease				
		Skin condition				
		Spina bifida				
	Substance abuse (alcohol, drugs, tobacco)					
		Suicide risk or attempt				
		Surgeries:				
		Thyroid disorder				
		Tics or twitches				
		Tourette's syndrome				
		Tuberculosis				
		Other				
T 7	3.7					
Yes	No					
		My child is healthy and has no special health needs.				
Yes	No	HEARING				
		Hearing loss: Hearing loss due to				
		[] RightMild ModerateSevere Last evaluation				
		[] LeftMild ModerateSevere				
		Hearing aid [] Right [] Left				
Yes	No					
		Color deficiency				
		Legally blind				
		Vision problem/Eye defect	Last eye exam			
		Wears glasses [] All the time [] For distance only [] For reading	only [] For sports			
		Wears contact lenses				
		ns: (Include prescription and over-the-counter medication)				
Name		Used to Treat				
	,					
MEDICA	TION	S IN SCHOOL: If your child has a medical condition that requires medication	a in echaol a writton physician's order is			
		medication may be carried in school or on a bus by a student; this applies to				
		eral exceptions for students needing emergency medications whose order sp				
		ir medication. All medication must be delivered to the school Health Office by				
		ten parental permission. Medication order forms are available through the He				
		l Health Concerns:				
Are there		ther medical diagnoses or disabling conditions that might require a modification in] No Specify:				
		n that would prevent full participation in educational programs (including ph before modifications can be considered.	ysical education) requires physician			
unders	tand th	at if my child's health status changes during the school year, I will provide the	Health Office with updated information.			
Parent/0	Guardi	an Signature D	Oate			
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