Anchorage School District  
HEALTH HISTORY FORM  
PLEASE COMPLETE FOR ALL NEW-TO-DISTRICT OR AS NEEDED  

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>M.I.</th>
<th>DATE OF BIRTH (MM/DD/YYYY)</th>
<th>SCHOOL</th>
<th>GRADE</th>
</tr>
</thead>
</table>

MEDICAL HISTORY  
☐ YES ☐ NO Does your child have any health concerns?  
If yes, please describe: ________________________________  

☐ YES ☐ NO Does your child have restrictions to participate in any activities?  
If yes, please describe: ________________________________  

☐ YES ☐ NO Does your child have any allergies?  
If yes, list allergies: ________________________________  
What does the allergic reaction look like? ________________________________  

☐ YES ☐ NO Is your child prescribed an EpiPen? For what allergies? ________________________________  

☐ YES ☐ NO Does your child have asthma?  
If yes, please describe type or triggers: ____________________________________________  

☐ YES ☐ NO Does your child have diabetes?  
Type: ___________________________  
☐ Self manage ☐ Needs supervision ☐ Uses insulin pump ☐ Uses CGM  

☐ YES ☐ NO Does your child have a heart condition?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have a bleeding disorder?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have an orthopedic condition?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have a history of seizures or another type of neurological disorder?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have any gastrointestinal concerns or issues with eating?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have any bowel or bladder concerns?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have behavioral, emotional, or mental health concerns?  
If yes, please describe: ____________________________________________  

☐ YES ☐ NO Does your child have any vision concerns?  
☐ GLASSES ☐ Other: ________________________________  

☐ YES ☐ NO Does your child have any hearing concerns?  
☐ HEARING AID ☐ Other: ________________________________  

☐ YES ☐ NO Does your child currently take medications?  
If yes, please list: ____________________________________________  

DO ANY PRESCRIBED MEDICATIONS OR TREATMENT PLANS NEED TO BE ADMINISTERED/AVAILABLE AT SCHOOL?  
☐ Diabetic medications/Diabetic Care Plan ☐ EpiPen/Allergy/Anaphylaxis Care Plan ☐ Inhaler/ Asthma Care Plan  
☐ Prescribed medications ☐ Seizure medications/Seizure Care Plan  
☐ Other Treatments (describe) ____________________________________________  

The ASD Nurse must be notified if any medications need to be given during the school day. State law requires written authorization from a health care provider and parent before any prescription medication can be given at school, including self-carry medication. All types of medication require an authorization/consent form AND the medication(s) must be delivered to the school by a parent/guardian in a pharmacy labeled container. Homeopathic and herbal remedies cannot be given at school.  

Please continue to the second page to complete this form.
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MEDICAL PROVIDER / PEDIATRIC GROUP: ________________________________ Phone__________________

OTHER PROVIDER: ________________________________ Phone__________________

PARENT / GUARDIAN CONSENT AND AUTHORIZATION

PERMISSION TO ACCESS STATE IMMUNIZATION REGISTRY

☐ I CONSENT ☐ I DO NOT CONSENT

...for the nurse to review my child’s immunization information in the State of Alaska immunization registry (VacTrak).
The parent/guardian can remove permissions at any time by submitting your request in writing.

PERMISSION TO RELEASE AND/OR EXCHANGE MEDICAL INFORMATION

☐ I CONSENT ☐ I DO NOT CONSENT

...for the nurse to contact the healthcare provider listed above to clarify medical information provided on this form. The nurse will share health information with school staff on a need-to-know basis for your child’s safety and to foster academic success. It is the responsibility of the parent/guardian to notify the nurse of any changes or updates in your child’s health history.

PARENT ACKNOWLEDGEMENT

My signature below is acknowledgement that the information provided is current and correct. I have reviewed the health history form and understand that it is my responsibility to notify the school when my child’s health information has changed. I agree to provide any medications or supplies needed for care of my child in school if needed. I will notify the school if my consent for the above items needs to be updated or changed, per my preference.

PARENT / GUARDIAN NAME (PRINTED) RELATIONSHIP TO CHILD TELEPHONE NUMBER

PARENT / GUARDIAN (SIGNATURE) DATE