



Anchorage School District HEALTH HISTORY FORM

**PLEASE COMPLETE FOR ALL NEW-TO-DISTRICT, PRESCHOOL, KINDERGARTEN, 5TH, AND 9TH GRADE STUDENTS
OR AS NEEDED FOR OTHER GRADES TO UPDATE NEW / EXISTING HEALTH CONCERNS**

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

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, please 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