

BURLESON ISD HEALTH DIVISION

Your child's health history will help us assess any physical condition(s), which may require adjusting his/her school program. This information will become a part of your child's record and will remain confidential. Pertinent information may be shared with appropriate personnel. Please complete the following and return to the school nurse. Thank you.

Student's Name: _____ **Birthdate:** _____
Campus: _____ **Grade:** _____ **Gender:** _____
Parent/Guardian: _____ **Phone:** _____
Student lives with: _____ **Phone:** _____
Additional phone #s: _____
Physician: _____ **Phone:** _____

Does your child take any medications routinely? Yes No taken at school?
Name of Medication Dosage Time Taken

*·All medications should be given outside school hours if possible. Three times a day medications can be given before school, after school, and at bedtime.
 ·Any medication to be given at school requires an additional medication form. Form available on BISD website.*

Does your child have a history of:

	Yes	No		Yes	No
Drug or Food Allergies (EpiPen required?) Yes No			ADD or ADHD medication taken at home? Yes No		
Environmental allergies (insect stings, ragweed, fire ant bites, seasonal) (EpiPen required?) Yes No			Chronic Dental Problems		
Headaches/Migraines			Genetic Disorders		
Diabetes			Operations/Hospitalizations		
Vision/Eye Problems			Physical Restrictions		
Hearing Problems			Chronic Earaches		
Speech Problems			Asthma <i>(If yes, check applicable statement)</i> Inhaler used frequently Exercise Induced- usually treated with inhaler Preventative medications taken- infrequent inhaler use Nebulizer treatments often necessary		
Broken Bones			Emotional Problems		
Urinary/Bladder Problems			Chickenpox <i>*If yes, date of disease: ___/___/___</i>		
Heart Problems					
Frequent Nosebleeds					
Blood Disorders					
Blood Pressure Problems					
Seizure Disorder					

If you answered "Yes" to any of the above, or if your child has medical problems not listed, please explain:

If your child has special medical needs, please contact your campus nurse to schedule an appointment to discuss care options.

Parent Signature: _____ **Date:** _____