Gallia County Local School District
Confidential Health History

Today's date:_________________ School enrolling in today:_________________________________

Student's Name: Last______________________, First______________________, Middle ________________

Current Grade: __________ Date of Birth:___________________ Gender: M/F IEP: Y/N

Parent's Name: _____________________________________ Home Telephone: _____________________

Address: ____ Work Telephone: _____________________

Please list student's siblings with their ages: ____

____

Did student's mother experience any problems with pregnancy, labor, or delivery: Y/N

Was student's growth and development abnormal: Y/N

If either question above was "yes", please list abnormality: ______________________________________

____

If your student has any allergies (food, medications, insects, latex, etc.) please list the allergy, what response the child has, and the treatment usually given: ____

____

Check any of the following that apply to this student:

☐ No Health Conditions	☐ Hay Fever	☐ Pancreatic Disorders
☐ Amblyopic	☐ Hearing Impairment	☐ Seizures
☐ ADHD/ADD	☐ Hearing Aides	☐ Skeletal Disorders
☐ ADHD medication	☐ Heart Problems	☐ Skin Problems
☐ Asthma	☐ High Blood Pressure	☐ Sinusitis
☐ Chickenpox	☐ Kidney Disorder	☐ Stomach Problems
☐ Color Blindness	☐ Learning Disability	☐ Stroke (CVA)
☐ Cystic Fibrosis	☐ Liver Disorder	☐ Urinary Disorder
☐ Diabetes	☐ Mental Disorder	☐ Uses Inhaler
☐ Dyslexia	☐ Menstrual Problems	☐ Vision Problems
☐ Ear Infections/Tubes	☐ Muscular Disorder	☐ Wears Glasses/Contacts
☐ Eating Disorder	☐ Migraines/Headaches	☐ Other health problems
	☐ Nosebleeds	

If you checked any of the above boxes, please describe the condition: ___________________________________

____

Has this student ever had any accidents or surgery, if so please list the date and nature of the injury/surgery:

____

Please list any medications/treatments this child must have (even if they do not need them at school): ______

____

Please list any concerns you may have about this child that the school nurse/teacher should be made aware of:

____

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I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that for the safety of my student, or to provide for their educational achievement, the school nurse may need to share information about my child with the appropriate school staff and/or associated agencies. Under the regulations of FERPA (Family Education Rights and Privacy Act of 1974), this information shall be shared in confidential manner only as necessary. If I do not want information shared, I must request this in writing and file this request with the school nurse.

This written validation will be in effect until otherwise noted or changed.

Signature of Parent/Guardian: ________________________________ Date: __________