THE PATHWAY SCHOOL

HEALTH HISTORY INFORMATION SHEET

Student name:	**Sex:** **Male** **Female**	**Date of birth**:

Medical History:
Have you ever been told by a physician or health care professional that your child has:

DIAGNOSIS	YES	NO	COMMENTS
Asthma			
Bleeding Disorder			
Bone/Muscle Disease			
Seizure Disorder			
ADD/ADHD			
Skin Disorder			
Diabetes			
Autism			
Birth/ Congenital Disorder			
Bowel/Bladder Problems			
Blood Disorders			
Cancer			
Cystic Fibrosis			
Depression			
Traumatic Brain Injury			
Other			
Other			

Does your child experience any of the following?

	Yes	No	comments
Nose Bleeds			
Overweight for Age			
Physical Disability			
Poor Appetite			
Frequent Stomach Aches			
Underweight for Age			
Frequent Headaches			
Fainting Spells			
Tires Easily			
Wears Hearing Aids			
Wears Glasses			

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Allergies:
Documentation for dietary allergies is required. (Please contact the school nurse)

Allergy	yes	no	comments
Animals			
Plants			
Food			
Bees			
Molds			
Medication			
Other			

Medication:

Does your child take any medication?
Yes_____ No_____

Name of medication	Purpose

Will medication be needed at school? Yes_____ No_____

If your child requires medication at school, please contact the nurse to discuss this and for the necessary authorization paperwork. Parent authorization, script/doctors order, medication placed in appropriate container with label matching the doctor's order must be received by the nurse before he/she can administer medication. Please note students are not permitted to carry medication on their person. Any prescribed medication for school must be either given to the bus driver by the parent who will in turn hand the medication to a member of staff at school, or the medication can be delivered to the school by a parent or pharmacy.

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child.

Parent/Guardian signature:

Print Name	Print Name
Signature	Signature
Date	Date