

**MEDICAL  
HISTORY UPDATE**

**DELBARTON SCHOOL 2010 –2011**

**Report of Parent**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Student's Physician \_\_\_\_\_

Address of Student's Physician \_\_\_\_\_ Telephone \_\_\_\_\_

**\*The school requests that you complete all sections of the following. Please be certain to sign the bottom of this form.**

**I. Family Health** - Health of father \_\_\_\_\_ Health of mother \_\_\_\_\_

Give cause of any deaths in immediate family \_\_\_\_\_

**II. Personal History - include dates**

Allergies to: Bee Sting \_\_\_\_\_ Medication \_\_\_\_\_ Food \_\_\_\_\_ Other \_\_\_\_\_

Indicate any change in health during the past year \_\_\_\_\_

Operations/ Injuries/ Serious Illnesses (indicate dates) \_\_\_\_\_

**III. General Considerations**

Eyes: Glasses worn \_\_\_\_\_ Contacts \_\_\_\_\_ Date of most recent exam \_\_\_\_\_

What recurrent or chronic conditions is the student predisposed to? \_\_\_\_\_

Has physical exercise been restricted in the last year? Explain \_\_\_\_\_

If student's physical condition is normal, is permission given to participate in the regular sports, including football? \_\_\_\_\_

Has your son received psychological/psychiatric treatment or evaluation for learning disability? If so, please give name and address of psychiatrist/institution. \_\_\_\_\_

Has there been any change in your family structure that would be beneficial for the nurse or administration to know about? If so please list and follow up with school nurse and/or guidance regarding any special needs. \_\_\_\_\_

**IV. Medication**

Is your son currently taking any prescribed medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please explain \_\_\_\_\_

**Please note that if your son does go on medication, or if there is a change in current medication, the School must be informed. If your child needs medication in school, please send the medication in the original prescription bottle and include written recommendation of the physician and written permission of the parent. If your child needs to carry an inhaler or any other medication needed for emergency use, the same policy applies. If your child needs an inhaler or epipen, an extra one should be kept at the nurse's office.**

**V. A separate form for medication is provided. THIS MUST BE COMPLETED BY PARENT AND PHYSICIAN FOR OVER THE COUNTER MEDICATION AS WELL AS FOR ANY PRESCRIPTION DRUGS.**

**Vi. Parental consent:** I understand that for the educational needs and safety of my child, the school nurse may share information about my child with appropriate school staff. This will be done in a confidential manner.

Yes, Permission is granted       No, permission is not granted

**Vii. Parental Permission for treatment**

The law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except in an extreme emergency, without parents being contacted and fully informed.

"If I cannot be reached, I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son."

Parent /Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_