# Student Health History Form (Page 1 of 2)

To Parent/Guardian,

To better serve your child and provide them with the best educational experience, we request that you complete a detailed health assessment so we can address your child's needs in the classroom. Information will only be shared with school personnel who have a legitimate educational interest in the information.

This is a general assessment so we can better understand your child. Should your child require medications, or other special health treatments or procedures, additional paperwork will need to be completed. Please complete this form and contact your school nurse as needed.

**PLEASE PRINT CLEARLY**

**Student Name** (Last, First, Middle) _____ **Birth Date** (Month/Day/Year) _____ **Today's Date:** _____

**Born:** Male ☐ Female ☐

**School** (Circle One):

SES | CES | AMS | AHS | AIHS

**Grade** _____ **Primary Care Provider Name** _____ **Clinic Name** _____ **MD Phone #** _____

## PERMISSION TO EXCHANGE INFORMATION (OPTIONAL)

I, _____ (Name of Parent/Guardian), authorize and request my child's primary care provider to exchange information about my child's health and development with Amesbury Public Schools. The information may be provided by phone, fax, mail, or in person. I understand that the disclosed information will be considered confidential and will be used for the health and educational benefit of my child and family. Except as needed to comply with federal and state regulations, it will not be re-disclosed to any other person, school, or agency without my consent. I understand that this form will expire in one year unless I choose to cancel my permission in writing before that time.

| | | | |
|---|---|---|---|
| Name of School requesting information | | Signature of Parent/Guardian | Date / / |
| School Mailing Address | , Amesbury, MA 01913 | Signature of Witness | Date / / |
| School Telephone Number | School Fax Number | Signature of School Nurse | Date |

## SCHOOL NURSE CONTACT INFORMATION:

| | | | |
|---|---|---|---|
| SMS | **Jordan Shay Memorial Lower Elementary School:** 193R Lions Mouth Rd | **School Phone:** 978-388-3659 | **Fax:** 978-388-4961 |
| | *School Nurse:* Nicole Quadros, BSN, RN | **Email:** Nicole.Quadros@AmesburyMA.org | |
| CES | **Cashman Elementary School:** 193 Lions Mouth Road | **School Phone:** 978-388-4407 | **Fax:** 978-388-4479 |
| | *School Nurse:* Kieran Ford, RN | **Email:** Kieran.Ford@AmesburyMA.org | |
| AMS | **Amesbury Middle School:** 220 Main Street | **School Phone:** 978-388-0515 | **Fax:** 978-955-2562 |
| | *School Nurse:* Jody Omohundro, BSN, RN, NCSN | **Email:** Jody.Omohundro@AmesburyMA.org | |
| AHS | **Amesbury High School:** 5 Highland Street | **School Phone:** 978-388-4800 | **Fax:** 978-388-4919 |
| | *School Nurse:* Michelle Parsons, BSN, RN | **Email:** Michelle.Parsons@AmesburyMA.org | |
| AIHS | **Amesbury Innovation High School:** 71 Friend Street | **School Phone:** 978-388-8037 | **Fax:** 978-388-8073 |
| | *School Lead Nurse:* Kristin Tierney, FNP-C, NCSN | **Email:** Kristin.Tierney@AmesburyMA.org | |

# **Student Health History Form** (Page 2 of 2)

**Student Name** (Last, First, Middle) _____ **Date of birth** (Month/Day/Year) _____

| | | | |
|---|---|---|---|
| Does your child have health insurance? | Yes | No | If you answered "No" to either of these questions, please contact the nurse for further assistance. |
| Does your child have dental insurance? | Yes | No | |

*Please answer these health history questions about your child to the best of your ability.*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Seasonal allergies | Yes | No | Immunity Problems | Yes | No | Is your child toilet trained? | Yes | No |
| Allergies to food | Yes | No | "Mono" (past 1 year) | Yes | No | Has only 1 kidney or testicle | Yes | No |
| Allergies to medication(s) | Yes | No | Chest pain | Yes | No | Sickle Cell Disease | Yes | No |
| Allergy to bee / insect stings | Yes | No | Heart (Cardiac) history/problems | Yes | No | Any problems with vision | Yes | No |
| Anaphylaxis | Yes | No | High / Low blood pressure | Yes | No | Limited physical activity | Yes | No |
| Any other allergies | Yes | No | Fainting or blacking out | Yes | No | Problems running | Yes | No |
| Concussion(s) / Head injury | Yes | No | Bleeding more than expected | Yes | No | Uses contacts or glasses | Yes | No |
| Headaches | Yes | No | Asthma treatment (past 3 years) | Yes | No | Any problems hearing | Yes | No |
| Migraines | Yes | No | Any smoking in the household | Yes | No | Any problems with speech | Yes | No |
| Traumatic brain injury | Yes | No | Problems breathing or coughing | Yes | No | Birth Defects | Yes | No |
| Seizure treatment (past 2 years) | Yes | No | Dental braces, caps, or bridges | Yes | No | Concerns with sleeping habits | Yes | No |
| Musculoskeletal problems (including cerebral palsy) | Yes | No | Does your child require a special diet? | Yes | No | Mental health/behavioral concerns (i.e., depression) | Yes | No |
| Any broken bones or dislocations | Yes | No | Bowel problems | Yes | No | ADHD / ADD | Yes | No |
| Any muscle or joint injuries | Yes | No | Stomach problems | Yes | No | Lead Poisoning | Yes | No |
| Any neck or back injuries | Yes | No | Excessive weight gain/loss | Yes | No | Surgeries | Yes | No |
| Any daily medications | Yes | No | Bladder problems | Yes | No | Any other health concerns | Yes | No |
| Diabetes | Yes | No | Any hospitalizations, or had any operations, procedures, or special tests? | | | | Yes | No |

If you **answered "Yes"** to any of the above questions, please further explain your answers here: _____

_____

_____

**All medications taken in school abide by Amesbury Public Schools Policies and Procedures for the Administration of Medications**

Does your child take ANY medications? Please list name(s) of medication(s): _____

_____

Please list any **medications** your child will need to take **during** school hours: _____

_____

Will your child require any emergency medication (e.g. epinephrine auto-injectors, inhalers, glucagon, diastat, etc.) to be administered in school? _____

Does your child require any special health treatments or procedures (e.g. tube feeding or catheterization)? Yes No

*If "Yes," please contact the school nurse for a meeting (contact info on Page 1).*

Would you like to request a meeting with your school nurse to discuss your child's needs? Yes No

By signing below I agree that the above information in regards to my child have been answered to the best of my ability.
Should there be any changes to my child's health status, I acknowledge that it is my responsibility to notify the nurse as soon as possible.

Print: _____ Sign: _____ Date: _____

Name of Parent/Guardian | Signature of Parent/Guardian | Today's Date