CITY OF MERIDEN
DEPARTMENT OF HUMAN SERVICES – HEALTH DIVISION
SCHOOL HEALTH PROGRAM

HEALTH HISTORY FORM

Dear PARENT/GUARDIAN: Please complete the information below and return this form to the **SCHOOL NURSE** as soon as possible.

Student's Name _____ ☐ Male ☐ Female Date of Birth _____

Address _____ Telephone # _____

School _____ Grade _____ Student's Physician _____

Parent/Guardian's Name ***(please print)*** _____

Please check (✓) if your child has or has had any of the following:

		Date
Anemia	____	_____
Asthma	____	_____
Blood Disorder	____	_____
Cancer	____	_____
Chicken Pox	____	_____
Dental Braces	____	_____
Developmental Disorder	____	_____
Diabetes	____	_____
Ear Disorder	____	_____
Endocrine Disorder	____	_____
Eye Disorder	____	_____
Fainting Spells	____	_____
Fifth Disease	____	_____
Fractures	____	_____
Frequent Headaches	____	_____
Genetic Disorder	____	_____
German Measles	____	_____
Head Injury	____	_____
Heart Disease	____	_____
Hepatitis	____	_____
Hyperactivity	____	_____
High Blood Pressure	____	_____
Immune Deficiency	____	_____
Kidney Disorder	____	_____
Lead Poisoning	____	_____
Liver Disorder	____	_____
Lyme Disease	____	_____
Measles	____	_____
Meningitis	____	_____
Menstrual Disorder	____	_____
Mononucleosis	____	_____
Migraine Headaches	____	_____
Mumps	____	_____
Muscle/Bone/Spine Disorder	____	_____
Nosebleeds	____	_____
Physical Limitations	____	_____

		Date
Pneumonia	____	_____
Premature Birth	____	_____
Rheumatic Fever	____	_____
Scoliosis	____	_____
Seizures	____	_____
Sickle-Cell Trait/Disease	____	_____
Skin Disorder	____	_____
Strep Throat	____	_____
Tuberculosis	____	_____
Toileting Difficulties	____	_____
Other_____	____	_____

ADDITIONAL INFORMATION:

1. Is your child allergic to:
   ☐ Medications *specify*_____
   ☐ Foods *specify*_____
   ☐ Bee stings ___ Other _____
2. Is your child taking medication(s)?
   ☐ Yes *specify* _____ ☐ No
3. Does your child wear glasses or contact lenses?
   ☐ Yes ☐ No
4. Does your child wear a hearing aid?
   ☐ Yes ☐ No
5. Does your child use a wheelchair/walker or wear a leg brace? ☐ Yes ☐ No
6. Has your child been in the hospital? ☐ Yes ☐ No
   Reason _____ Date _____
7. Has your child had surgery? ☐ Yes ☐ No
   Type _____ Date _____
8. Does your child have health insurance?
   ☐ Yes ☐ No
9. Does your child see a dentist? ☐ Yes ☐ No

Parent/Guardian Signature _____ Date _____

Rev. 2/01
lt

Historial de Salud

APRECIADOS PADRES/GUARDIAN: Favor de completar la forma debajo y devolverla a la **enfermera de la escuela** lo antes possible.

Nombre del Niño: _____ Fecha de Nacimiento: _____

Dirección: _____ Telefóno: _____

Medico del Estudiante: _____ Escuela/Grado: _____

Nombre del Padre/Guardian: _____

Por favor marcar (✓) si su niño ha tenido algunos de los siguientes:

Anemia _____
Asma _____
Desorden en la Sangre _____
Cancer _____
Varicela _____
Ganchos Dentales _____
Desorden con el Desarollo _____
Diabetes _____
Desordenes de los Oidos _____
Desordenes Glandular _____
Disordenes de la Vista _____
Desmayos _____
Fracturas _____
Dolores de Cabeza Frecuentes _____
Desorden Geneticos _____
Sarampión Alemán _____
Lesión en la Cabeza _____
Enfermedad de Corazión _____
Hepatitis _____
Hiperactivo _____
Problema con la Presión Alta _____
Deficiencia Inmune _____
Desordenes de los Riñones _____
Envenenamiento de Plomo _____
Desorden del Higado _____
Enfermedad Lyme Disease _____
Sarampión Común _____
Meningitis _____
Desordenes con la Menstruación _____
Mononucleosis _____
Migraña _____
Paperas _____
Problemas Ortopedicos _____
Sangrar por la Nariz _____

Limitaciónes Fisicas _____
Pulmonia _____
Fiebre Reumatica _____
Scoliosis _____
Convulsiones (ataques) _____
Sickle-Cell Anemia _____
Desorden con la Piel _____
Streptococco de la Garganta _____
Tuberculosis _____
Problema Cuando va al Baño _____

Información Addiciónal:

1. Es su niño alerjico a?
   ☐ Picada de a bispas ☐ Medicamentos
   ☐ Comidas Otros _____
2. Esta su niño tomando medicamentos?
   ☐ Sí Tipo: _____ ☐ No
3. Usa su niño espejuelos o lentes de contacto? ☐ Sí ☐ No
4. Usa su niño audifono para oir?
   ☐ Sí ☐ No
5. Usa su niño una silla de ruedas/andador o ganchos ortopedicos para los piernas?
   ☐ Sí ☐ No
6. Ha estado su niño hospitalizado?
   Razón: _____
   Fecha: _____
7. Ha tenido su niño alguna operación/cirugia?
   Tipo: _____
   Fecha: _____
8. Tiene su niño seguro medico?
   ☐ Sí ☐ No
9. Visita su niño al dentista?
   ☐ Sí ☐ No

Firma de Padre/Guardian _____ Fecha _____

CITY OF MERIDEN – SCHOOL HEALTH PROGRAM

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a written order from a licensed Advance Practice Registered Nurse, Physician Assistant, Physician or Dentist and parent or guardian's authorization for a nurse to administer all medications or in her absence, the principal or teacher to administer medications. Medications must be in the original labeled container as dispensed from pharmacy or medical office. All medications shall be delivered to the school by the parent, guardian or other responsible adult.

Name of Student _____ D.O.B. _____

Address _____ Allergies _____

Condition for which drug is being administered during school hours _____

_____

DRUG: Name, dose and method of administration _____

_____

Time of administration _____ Medication shall be administered from _____ to _____
date *date*

Possible side effects and management _____

Is this a controlled drug? Yes _____ No _____ If yes, DEA number _____

If not a controlled drug, is this student capable of self-administering this drug? Yes _____ No _____

Is this medication to be administered on field trips and shortened school days? Yes _____ No _____

Health Care Provider Name _____ Telephone # _____
Type or print

Address _____

Health Care Provider's Signature _____ Date _____

AUTHORIZATION OF PARENT OR GUARDIAN

SCHOOL _____ DATE _____

TO SCHOOL PERSONNEL:

I hereby request that the above medication ordered by the health care provider for my child be: *(please check)*

_____ self administered
_____ administered by school personnel

I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a health care provider or pharmacist and will provide no more than a 45 school day supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Signature _____ Relationship to Child _____

Address _____ Phone _____

AUTHORIZED MEDICAL CONSULTANT/SCHOOL MEDICAL ADVISOR

Signature _____ Date _____

lt 8/00

MEDICATION POLICY

Connecticut State Law and Regulations require a licensed Advance Practice Registered Nurse, Physician's Assistant, Physician, or Dentist's written order and parent or guardian's authorization for a nurse to administer medications or, in her absence, the principal or teacher to administer medications. Medications must be in a pharmacy prepared container, which is brought to school by a ***person over 18 years of age,*** and left in school for the duration of the medication. It must be labeled with name of child, name of drug, strength, dosage, frequency, health care provider's name, and date of original prescription.

The form on the reverse side of this policy should be filled out: top half by the health care provider and the bottom half by the parent or guardian.

Any medication ordered three times a day, twice a day, or once a day is given at home unless specifically ordered by the health care provider to administer during school hours.

When a prescription is taken to the pharmacy and medication is needed for school, let the pharmacist know that you need a school container as well as a container for home. The pharmacist will see that this need is met for the school.

All medication coming into the school is brought in by an adult or guardian, 18 years of age or older, and must be picked up by an adult as well. Children are not allowed to transport or have medication in their possession.