

**PAYSON UNIFIED SCHOOL DISTRICT
MEDICAL HISTORY INFORMATION**

Campus: _____ Grade: _____ School Year: _____

Student Name: _____ Date of Birth: _____

If your child has been diagnosed with or is experiencing any of the following health related conditions, disabilities, or disorders please provide related information below. Provide additional data as needed.

<u>Allergies</u> Yes No	Food Environmental Medication Skin Sensitivity Other Please explain: _____
<u>ADHD etc.</u> Yes No	Diagnosis: _____ Medication _____ Dose _____
<u>Asthma</u> Yes No	Inhaler (type) _____ SVN Treatment (type) _____ Induced by: _____
<u>Bleeding Disorder</u> Yes No	_____ _____
<u>Cardiac</u> Yes No	Type (including heart murmur: _____ Restrictions: _____
<u>GI Issues</u> Yes No	_____
<u>Diabetes</u> Yes No	Type: ____ Date Diagnosed: _____ Insulin Dependent: Yes No
<u>Feeding</u> Yes No	_____
<u>Hearing/Ear</u> Yes No	PE tube placement: Yes No If yes, when _____ Hearing aids: Right Left
<u>Neurological</u> Yes No	Type (including migraines) _____
<u>Orthopedic</u> Yes No	_____
<u>Urinary</u> Yes No	_____
<u>Vision</u> Yes No	Glasses? Yes No History of Surgery? Yes No If yes, when: _____

Due to the confidentiality laws, the health office needs a signed form of consent to discuss your child's health concerns with pertinent school staff members. This would include staff such as teachers, para-professionals, and cafeteria personnel.

This information would be strictly on a need to know basis and shared only with those staff members that have direct contact with your child or may be able to assist your student with their specific medical condition.

Please inform the Health Specialist or Nurse at your child's school if there is any change or additional medical conditions they should know of.

Parent/Guardian signature: _____ Date: _____