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.

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