Newark Community High School Student Health History '22-'23

To be Completed by a Parent or Guardian for ALL students each year

Student Name:_____ Date of Birth: _____ Grade:_____

Parent/Guardian Name:_____ Phone:_____

Medical Provider Name:_____ Phone: _____ Hospital Preference: _____

HEALTH CONDITION - Please mark any health conditions your child has been diagnosed or treated for below:

	✓		✓		✓		
Asthma**		Hearing Impairment		Seasonal Allergies		Past Events/Surgeries	
Autoimmune or Endocrine Disorder		Wears Hearing Aids		Learning Disability		Mental Health Hospitalization	
Bleeding Disorder		Heart Problem/Murmur		ADD/ADHD		Anaphylactic Reaction**	
Bowel/Bladder Issue		Menstrual Disorder		ASD (Autism)		Head Injury	
Diabetes**		Migraines**		Past Trauma		Appendectomy	
Dizziness/Fainting		Mononucleosis		Anxiety/Depression		Tonsillectomy:	
Epilepsy/Seizures**		Vision Impairment		Eating Disorder		Other:	
Joint/Mobility Issues		Wears Glasses/Contacts		Emotional Difficulties			

If you checked "yes" to any of the above conditions, please explain relevant details or care information below:

**All conditions with asterisk marking require a corresponding Action Plan on file.

ALLERGIES - Please list any allergy(s) and the reaction your child experiences in the spaces below:

Allergy to:	Reaction (ex. Hives, GI upset, trouble breathing):	Additional Comments:

MEDICATIONS: Include both prescription & over-the-counter medicines your child is taking in the spaces below:

Medication Name:	Dose:	Times/Day:	Note:

*If your child may need medicine at school, please review the school policy and fill out a Medication Authorization Form.

Permission for Rapid Antigen Test **yes** **no**

I understand that this form is kept confidential and will be kept in my child's health records. The information will assist school administration to care for my child in case of an emergency. My signature gives permission for relevant information to be shared privately with specific teaching staff when needed for the safety and individualized care of my child. I understand that I should contact the school nurse if I wish to discuss anything pertaining to my child's health.

Parent/Guardian Signature: _____ **Date**:_____