

POTEAU PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

SCHOOL: \_\_\_\_\_ PRESENT GRADE: \_\_\_\_\_ DATE: \_\_\_\_\_

CHILD'S FULL NAME: \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

PRESENT ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT OR LEGAL GUARDIAN: \_\_\_\_\_  
(last) (first) (Middle)

HEALTH HISTORY: (Please give dates where known)

Operation (within last year) \_\_\_\_\_

Emotional problems (i.e. hyperventilator, hysteria) \_\_\_\_\_

Serious medical problems \_\_\_\_\_

Rheumatic fever \_\_\_\_\_

Diabetes \_\_\_\_\_ Epilepsy \_\_\_\_\_

Allergy \_\_\_\_\_ Tetanus (last injection) \_\_\_\_\_

Any special health problems in past? \_\_\_\_\_

(continue on back)

Allergy to drugs (specify i.e. Penicillin, Insulin, etc.) \_\_\_\_\_

Any medications student is on: (include anti-convulsive, antihistamine, insulin and tranquilizers) \_\_\_\_\_

Is child under medical treatment at present? \_\_\_\_\_ (reason) \_\_\_\_\_

Family Physician \_\_\_\_\_

Telephone No. of Physician (include area code) \_\_\_\_\_

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I give my permission for the treatment of my child by a physician and at a hospital for a medical or surgical condition. This includes out-of-town activity trips.

SIGNATURE OF PARENT OR LEGAL GUARDIAN

I give my permission for coaches to give my child over the counter drugs such as salt tablets, vitamins and pain pills (aspirin, Tylenol, etc.).

SIGNATURE OF PARENT OR LEGAL GUARDIAN

Insurance Company \_\_\_\_\_

Agreement No. \_\_\_\_\_ Group No. \_\_\_\_\_

I give my permission for a school employee designated by the principal to administer medication to my child. Only medication sent to school by the parents will be administered. I understand that the medication must be in its ORIGINAL CONTAINER and that the CONTAINER MUST BE LABELED with directions for administering.

SIGNATURE OF PARENT OR LEGAL GUARDIAN