Missoula County Public Schools
CONFIDENTIAL Student Health History

Full Student Name_____ Grade_____

School:_____ Date of Birth_____

School staff is informed of health conditions & treatments on a need-to-know basis to keep students safe. Information provided is used to treat the student in class/activities, when they visit the health office, and may also help us understand learning needs.
Note: Food *preferences, lifestyle/religious diets* are addressed between the parent/guardian and student and not the school's responsibility to monitor.

Please indicate yes or no if your student has or previously had issues related to the following conditions. If you answer yes, please provide details below or attach additional information. Asterisks* indicate additional forms or information may be needed. Please use blue or black ink

Condition	Yes	No	Details	Condition	Yes	No	Details
ADHD, ADD				Frequent/recurring			
Autism				Dizziness			
Allergy- ***Life-threatening**				Headache			
***Epi Pen prescribed**				Infections			
Allergies-other				Migraine			
Asthma				Nose bleeds			
***inhaler at school**				Pain			
Anemia				Stomach ache/nausea			
Bleeding disorder				Head injury/concussion dates:			
Arthritis				Heart Disease/condition			
Behavioral/emotional				Hospitalizations			
Bladder/bowel/urinary				Immune system issues			
***Ostomy**				Lung/breathing conditions			
Bone/muscle/joint problems				Mental health /psychiatric			
Fractures/broken bones				Mobility/assistive device			
Developmental delays				Neurologic/neuromuscular			
***Diabetes**				***Seizures (indicate type)**			
Ear/hearing				***Rescue meds**			
Wears hearing aid(s)				Daily seizure meds			
Sign language				Sleep			
Eye/vision/color vision				Apnea			
Wears glasses/contacts				Snoring			
Color blind/deficient				Skin conditions/rash			
***Feeding Tube**				Speech/communication			
***Food intolerances**				Surgeries (Date/type)			
List food & reaction				Other:			
ADDITIONAL INFORMATION:							

***Medications & treatments**-list all meds, treatments, etc. **Please attach or enter additional information above, if needed.**

1. Treatment/med_____ Times needed_____ For_____
2. Treatment/med_____ Times needed_____ For_____
3. Treatment/med_____ Times needed_____ For_____
4. Treatment/med_____ Times needed_____ For_____

In case of an accident or serious illness, the school will provide first aid and contact a parent/guardian to obtain further medical attention. The school may notify emergency services if deemed necessary. If appropriate and the school is unable to contact the parent, the school may contact the medical provider listed below and follow his/her instructions.

Health care provider(s)_____ **Phone(s)**_____

Parent/guardian signature_____ **Date**_____