# Missoula County Public Schools
# Confidential Student Health History

School: _____
Grade: _____

Student Name: _____ Birth Date: _____

Dear Parent:

The school may notify your child's teacher(s) and other school staff any information you give below if needed to keep your child safe and healthy at school. NOTE: Asterisks indicate associated forms. Food ***PREFERENCES*** are between the parent /guardian and child and not the school's responsibility to monitor.

□ Food INTOLERANCES: To what with what symptoms: _____

□ ALLERGIES: To what? _____

Symptoms your child had: _____

What medications were used to treat those symptoms? _____

Has your child ever been given a written prescription for epinephrine (Epipen)? Yes * No

□ Yes, my child needs supervision to avoid foods they are *ALLERGIC* to OR *INTOLERANT* of. See forms below.

□ Asthma OR Reactive Airway Disease: What "triggers" cause asthma symptoms in your child?

□ Exercise □ Respiratory infection such as a cold □ Smoke □Foods: List: _____

□ Other _____

What medications does your child use for asthma? _____

Will/does your child have an inhaler in the school office? □ **Yes*** □ No Carry inhaler with them? □ **Yes*** □ No

□ Concussion History: Number and approx. dates of concussions: _____ Was concussion diagnosed by a health care provider (doctor, etc.)? □ Yes □ No Other: _____

□ Diabetes: Type: _____ Medications: _____ □ Pump □ Injections

□ Seizures: Type: _____ Date of last seizure: _____

Current anti-seizure medications: _____

□ Hearing loss or impairment: Describe: _____ □ Wears hearing aid

Is the hearing loss significant enough that your child may need accommodations? □Yes □ No

□ Vision Impairment: Describe: _____ Wears glasses or contacts? □Yes □ No

Is the vision problem significant even with glasses/contacts that your child may need accommodations? □Yes □ No

□ Surgeries: Type and Date: _____

□ Hospitalizations: Date and cause: _____

□ Other Health Conditions, physical restrictions or medication at home that may require consideration at school:

_____

_____

_____

| MEDICATION & *FORMS | | | |
|---|---|---|---|
| | • Provide a permission form signed by parent and healthcare provider each year for all medications.<br>• Parent must bring in medications to the school office in the original pharmacy or manufacturer labeled container themselves. (not the student in order to ensure safety for all)<br>• Medications must be kept in the school office except for life saving medications, (Epipen (epinephrine), inhalers, and diabetic medications that the student has been authorized to carry)<br>• Ask the school secretary or nurse for the correct forms or download from www.mcpsmt.org | | |
| | Authorization for Medications | "Standing Order" Medication K-8 High School | Diet Request Form (for intolerances) |
| | Asthma/Bronchodilator Authorization | Anaphylaxis Action Plan | Food Substitution Medical Statement (severe allergy) |

In the case of accident or serious illness, the school will provide first aid and contact the parents 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.

In case of emergency: Health Care Provider: _____ Phone: _____

_____ _____

Parent/ Guardian Signature Date