# COLLIER SCHOOL

Student Health History

Student Name:_____DOB:_____Gender: _____
Dear Parent/Guardian,
Please complete the following Health Questionnaire for your child and notify your child's school nurse should any health or medication changes occur during the school year.

- Allergies to (Please check all that apply): Food (type)_____
  Insect sting_____ Latex_____ Seasonal_____ Other/Unknown_____
  Type of Reaction: Mild_____ Moderate_____ Anaphylactic_____
  Please provide a completed **Emergency Allergy Form** for Epinephrine if needed.
- Asthma_____ If an inhaler/Nebulizer is needed in school please provide a completed **Asthma Treatment Plan**.
- Seizures/Epilepsy_____ If yes, please provide a copy of the **Seizure Action Plan.**
- Diabetes Type I_____If yes, Please provide the **Diabetes Medical Management Plan**
  Diabetes Type 2____
- Celiac Disease, IBS or Other Gastrointestinal Issues (please specify)_____
- Incontinence issues/bladder/kidney condition type_____
- Muscle/Bone Disorder & Type_____ Arthritis_____
- Cardiac/Heart Disease & Type_____
- Excessive Headaches and/or Migraines_____
- Vision problems (Please specify) _____Glasses__yes no___
- Hearing issues (please specify)_____
- Excessive nosebleeds or other bleeding issues_____
- Scoliosis_____ Sickle Cell Anemia_____
- Eating Disorder/Feeding Issues_____
- Other Health conditions not listed_____

Does your child take medication daily? If so please list medication name, dosage and time:
_____

Has your child had surgery within the past year? If so please list type of surgery below:
_____

Is there anything more the nurse should know concerning your child's health? Please list:
_____

I/We give permission for the nurse to disclose this health information with school staff on a Need to know basis. Please be assured that any health information will be treated with confidentiality.

_____ _____
Parent/Guardian Signature Date