

Health History

Name		Date of Birth		
Gender	School		Grade/Tea	acher
Physician		Dentist		

School Year_____

The school district considers this to be personal, confidential information that will be treated in a discreet manner. The form may be reviewed by the school nurse, the classroom teacher, the building administrator, and other educators on a need to know basis.

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTH CARE PROVIDER WITH ANY OF THE FOLLOWING:

Health Condition	Yes	No	Explanation if "Yes"				
Allergies Bee Stings Food Allergies Other			Does your child require an EpiPen? List: EpiPen? Yes□No□ List: EpiPen? Yes□No□				
ADD/ADHD			Medication:				
Asthma			Asthma medication taken at home: Medication required at school:				
Autism Spectrum Disorder			Describe: Verbal ☐ Non Verbal ☐ Medications:				
Bowel/Bladder Issues			Describe:				
Diabetes			Type 1 (insulin dependent) Type 2 Diabetes medications:				
Hearing Loss			Right Ear Left Ear Hearing Aids				
Heart Condition			Describe:				
Mental Health/Emotional/Behavioral			Describe: Medication/Treatment:				
Seizure Disorder			Type of Seizure: Medications:				
Serious Injury			Describe: Dates:				
Surgery			Describe: Dates:				
Vision			Glasses Contacts For Distance For Reading				

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Other			Describe:		
Please list medications taken at					
Home if not already listed:					
Medication			Dose How of	ten Re	eason
			/ledications		
Helena School District requires writted prescription or over-the-counter med written permission from a Health Calprescription medications only. School to give to students. An <i>Authorization</i> or from the Helena School District we	dication re Provi ol Nurse on for Me	can be der and s do no edicatio	given to students K-8 gr parent/guardian must b t have over-the-counter os to be Given at School	ades at school. be provided for a medications (Ty form is available	For High School student dministration of denol, Ibuprofen, Tums) from your School Nurse
Parent/Guardian Signature			Printed Name		Phone
,					
imMTrax Consent Form for Children					
					ImMTrax Mentane Immediation Information System DPHHS
Child's Name:			Sex: M F	Date of Birth:	
I authorize my health care provider and a Department of Public Health and Human system that contains immunization recor agency as well as my health care provider released to child care facilities and schoo understand that I can revoke this authoridepartment.	public h Services ds. I und rs to assi ls in whi	nealth a o' Immu Ierstand ist in my ch my c	gency to collect and enter nization Information Syste that information in the re child's medical care and t nild is enrolled to comply v	my child's immur em (IIS). The IIS is egistry may be rel creatment. In add with state immun	nization records into the a confidential, computer eased to a public health ition, information may be ization requirements. I
Parent/Guardian Signature				Date	

Revised 4/2018 Form: 3176