RIVERSIDE UNIFIED SCHOOL DISTRICT
Health Services
5700 Arlington Avenue, Riverside, CA 92504

CONFIDENTIAL **HEALTH HISTORY FORM**

School_____

Student Name_____ ☐ **Male** ☐ **Female** ☐ **Nonbinary**

Birthdate_____**Age**_____**Grade**_____

☐ *My child **does not** have any health issues at this time.*

If your child has health issues please answer the following questions:

Does your child take medication on a routine basis? ☐ Yes ☐ No ☐ During school hours? ☐Yes ☐ No If yes,

Name of medication_____Name of medication _____

Name of medication_____Name of medication_____

If your child must take prescriptions or over the counter medications during the school day, complete the Medication Administration parent/physician authorization form and return to the school office. (One form for each medication).

Check ☑ the box and explain if your child has a history of or now has the following conditions or concerns.

☐ **Asthma**
☐ **Seizures**
- ☐ Date of last seizure _____
- ☐ Type_____
- ☐ Currently takes medication for seizures

_____

☐ **Allergies**
- ☐ Bees
- ☐ Foods_____
- ☐ Medication _____
- ☐ Other _____

☐ **Lactose Intolerance**

☐ **Physical Limitations** _____
- ☐ **Special Equipment needed at home**
- ☐ **Special Equipment needed at school**

☐ **Heart/Cardiac Condition**_____

☐ **Other Conditions** _____

☐ **Diabetes** ☐ **Type I** ☐ **Type II**
- Has your child been hospitalized for diabetes? ☐ Yes ☐ No
  If yes, give date and explain hospital course: _____
- Can your child monitor his/her blood glucose level independently? ☐ Yes ☐ No
- Can your child tell if he/she is having symptoms of high or low blood glucose levels? ☐ Yes ☐ No
  If yes, what are his/her symptoms? _____
- Has Glucagon ever been given to your child? ☐ Yes ☐ No Last given: _____

Is your child *currently* under a doctor's care for any of the above? ☐ **Yes** ☐ **No**
If yes: Doctor's name_____**Phone**_____**Fax**_____

Address_____

☐ **I hereby give permission to share information pertaining to the health of my child with school staff who need to know.**

Parent/Guardian Signature_____***Date*** _____

For Office Use Only:
☐ Original to Cum ☐ Sent to District Nurse ☐ *Health Assistant* ☐ Teacher