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

CONFIDENTIAL HEALTH HISTORY FORM

School_____

Student Name _____ ☐ **Male** ☐**Female** **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** ☐ Mild ☐ Moderate ☐ Severe
☐ Inhaler at home ☐ Inhaler at school office

☐ **Seizures** ☐ As an infant only
☐ Currently takes medication
_____

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

☐ **Allergies** ☐Mild ☐ Moderate ☐ Severe
☐ Bees/insects
☐ Foods _____
☐ Seasonal Hay fever
☐ Allergic to Medication _____
☐ Other _____
☐ EpiPen at home ☐ EpiPen at school

☐ **Heart Murmur/Disease** _____

☐ **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:
☐ Doctor's orders completed including parent and physician signatures.
☐ Diabetic Supplies
☐ Snacks
☐ Signed *Diabetic Treatment Plan for School* indicating parent review

☐ Original to Cum ☐Faxed to District Nurse 951-274-4200 (Internal #83100) ☐ *Health Assistant* ☐ Teacher