CHRISTINA SCHOOL DISTRICT STUDENT HEALTH HISTORY

Student:		ID# :	School	Year

Current guidelines for Coronavirus, from Delaware Public Health (DPH), Center for Disease Control (CDC) & World Health Organization (WHO) will be followed for the school year

Student Health History Update: This information will be shared with staff and administration on a need to know basis, and with emergency medical staff in the case of an emergency, unless you notify us otherwise.

1. Has your child been out of the country for more than one month in the past year? ☐ Yes ☐ No

If so, where?_____

2. Have you, your child or anyone in your household tested positive for COVID-19? ☐ Yes ☐ No

If Yes, please contact your School Nurse

3. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

☐ ADHD	☐ Bleeding	☐Concussion	☐ Heart	☐ Seizures	☐ Other: _____
☐ Allergies	☐ Body Piercing/Tattoo	☐ Diabetes	☐ Infections	☐ Speech	_____
☐ Asthma	☐ Bone Problem	☐ Emotional	☐ Kidney	☐ Surgery	***An Asthma or Seizure Action Plan is required for all students with either Asthma or Seizures***
☐ Behavior	☐ Bowel/Bladder	☐ Hearing	☐ Physical Disability	☐ Vision	

Comments: _____

4. Does your child have allergies to medicine, latex, insect bites or other allergies? ☐ Yes ☐ No

To What?: _____ What Happens?:_____ Treatment: _____:

5. Does your child have a food allergy diagnosed by a licensed health care provider? ☐ Yes ☐ No

To What?: _____ What Happens? _____ Treatment:_____

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy.

6. Has your child seen a healthcare provider since school ended in June? ☐ Yes ☐ No

What for? _____

7. Is your child being treated or evaluated for any health conditions? ☐ Yes ☐ No

List condition(s): _____

8. Is your child on any medication or treatment? ☐ Yes ☐ No

Name of medication or treatment: _____

Does your child need medication during school hours? ***If yes, please contact the school nurse to make arrangements***. ☐ Yes ☐ No

9. Has your child been prescribed glasses or contact lenses? ☐ Yes ☐ No

Date of last exam:_____ If your child wears glasses or contact lenses, when was the prescription last changed? _____

10. Has your child had any major life events, such as recent move, death, separation, divorce, etc. since the end of last school year? ☐ Yes ☐ No

If Yes, please contact your School Nurse or School Counselor.

Medical Information			
Family Physician:		Phone	
Family Dentist:		Phone	

I give permission for my child to have Acetaminophen (Tylenol®) as determined by the nurse. ☐ Yes ☐ No

I give permission for my child to have Ibuprofen (Advil®) as determined by the nurse. ☐ Yes ☐ No

I give permission for my child to have First aid cream_____Caladryl®_____Tums®_____ ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____

School Emergency Procedures: Your schools have adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician until one is reached.
7. The information on this form may be shared with emergency medical staff.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

Parent/Guardian Signature: _____ **Date:**_____