



Box Elder School District

# Box Elder School District

Dr. Ron Tolman, Superintendent  
O. Jay & Tamra Call Education Center  
960 South Main Street  
Brigham City, Utah 84302

## STUDENT HEALTH HISTORY

This form is to provide the school nurse (and other school and district personnel, if needed) with information regarding your student's health needs. The school nurse may contact you for further information. The information requested is considered to be essential to meet the needs of your child. This information will be kept confidential. Please complete this form and return it to your child's school or to the School Nurses Office.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Student's Home Phone #: \_\_\_\_\_

Student's Physician/Clinic: \_\_\_\_\_ Physician/Clinic Phone #: \_\_\_\_\_

### Please check the appropriate box(es) for medical concerns your child has:

- |  |   |
|--|---|
| <input type="checkbox"/> ADD/ADHD                  | <input type="checkbox"/> DIABETES                         |
| <input type="checkbox"/> ALLERGIES                 | <input type="checkbox"/> Insulin                          |
| <input type="checkbox"/> Bee Stings                | <input type="checkbox"/> Insulin Pump                     |
| <input type="checkbox"/> Peanuts                   | <input type="checkbox"/> HEARING PROBLEMS                 |
| <input type="checkbox"/> Tree Nuts                 | <input type="checkbox"/> HEART PROBLEMS (describe): _____ |
| <input type="checkbox"/> Other (list): _____       | _____   |
| <input type="checkbox"/> ANAPHYLACTIC ALLERGY      | <input type="checkbox"/> HYDROCEPHALIC                    |
| <input type="checkbox"/> Epi-pen*                  | <input type="checkbox"/> MIGRAINE HEADACHES               |
| <input type="checkbox"/> ANEMIA                    | <input type="checkbox"/> SERIOUS INJURY                   |
| <input type="checkbox"/> ASTHMA                    | <input type="checkbox"/> OTHER (please describe): _____   |
| <input type="checkbox"/> Inhaler*                  | _____   |
| <input type="checkbox"/> BLADDER OR BOWEL PROBLEMS | _____   |
| <input type="checkbox"/> DEPRESSION                |   |

### NO MEDICAL CONCERNS AT PRESENT TIME

The School Nurses have Health Care Plans for the above health concerns. Health Care Plans should be updated yearly (unless changes occur sooner). If you would like the School Nurses to contact you in order to create and/or update a Health Care Plan for your student, please check the appropriate box.

- Please contact me to create/revise a Health Care Plan
- I do not wish to be contacted to create/revise a Health Care Plan

Please list any medication(s) your student is currently taking for the above conditions: \_\_\_\_\_  
\_\_\_\_\_

\*A medication form must be completed and returned to the school before any medication can be given. This includes self-administered medication such as inhalers and epi-pens. Please contact your child's school or the School Nurses Office to obtain the necessary form(s) and/or for a copy of the District Medication Policy.

**I give permission to Box Elder School District in the event of medical necessity to access emergency medical treatment, transport if necessary, and consent to the release of this information to all appropriate school staff and/or EMS/ER personnel.**

*My signature below indicates that I have read and understand the above statements. I will update this information if/when changes occur.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Office of the School Nurses

Phone: 435-734-4800 | Fax: 435-734-4833 | Web: www.nurses.besd.net