STUDENT HEALTH HISTORY (2024-2025)

*This form must be completed by a PARENT/GUARDIAN **EVERY YEAR** for EVERY STUDENT

____ ______/______/_________ ________________

Student's Last Name First Name Middle Date of Birth Grade

____ ______________________________

#1 Parent/Guardian Name (***Will be notified FIRST**) Phone #

____ ______________________________

#2 Parent/Guardian Name Phone #

Name of Primary Care Doctor/Clinic: ______________________________Phone: ________________________

Health Insurance: ☐ No ☐ Yes

Company: ____________________ Subscriber's name: __________________ Policy Number: ______________

ALLERGIES *Does your child have:

	NO	YES	PLEASE LIST
Allergies to FOODS?			
Allergies to MEDICATIONS?			
Allergies to OTHER? (Latex, Bees, Environmental)			

Does your child have an **EPI-PEN OR EPINEPHRINE AUTO-INJECTOR?** ☐ No ☐ Yes

For what Allergy? ____

*Please read the **EXCEL STUDENT HEALTH INFORMATION** for **medication requirements**. Contact the **School Nurse** if you have any questions.

MEDICAL INFORMATION Please check **all** health conditions that relate to your child:

☐ Ear Infections (recent) ☐ Migraines
☐ Strep Throat (recent) ☐ Headaches (other)
☐ Seizure Disorder

☐ Asthma
☐ Other Wheezing ☐ Gastric Reflux
☐ Nasal Allergies ☐ Lactose Intolerance
☐ Nose Bleeds ☐ Constipation
☐ Celiac Disorder

☐ ADHD ☐ Kidney (Renal) Condition
☐ Anxiety ☐ Heart (Cardiac) Condition
☐ Depression ☐ Diabetes: ☐ Type 1 ☐Type 2
☐ Autism Spectrum ☐ Bleeding Disorder
☐ Emotional Concerns ☐ Vision Problem:
☐ Glasses ☐ Contact Lenses
☐ Scoliosis ☐ Hearing Problem:
☐ Other Bone Condition ☐ Hearing Aid

Any **Hospitalizations**? ☐ No ☐ Yes Reason: ______________________________
Any **Surgeries/Procedures**? ☐ No ☐ Yes Reason: ______________________________
Any Previous **Concussions**? ☐ No ☐ Yes Explain: ______________________________

Please comment on any conditions which you have checked or **note any other health concerns** your child has:

____
____
____

Does your child have **ASTHMA** (OR OTHER CONDITION THAT CAUSES **WHEEZING**)? ☐ No ☐ Yes

If YES, does he/she use an **INHALER?** ☐ No ☐ Yes

*Please read the **EXCEL STUDENT HEALTH INFORMATION** for **medication requirements**. Contact the **School Nurse** if you have any questions.

MEDICATIONS **Please list ALL medications** your child takes regularly (including those at home and at school).

MEDICATION NAME	DOSE	TIME(S) GIVEN	CONDITION

Will your child need to take **any prescribed medication at school?** ▢ No ▢ Yes
***If YES**, *Please read the **EXCEL STUDENT HEALTH INFORMATION** for **medication requirements**. Contact the **School Nurse** if you have any questions.

OVER-THE-COUNTER MEDICATIONS (GIVEN BY SCHOOL NURSE):

At times, students may not feel well while at school or may have a minor injury. The Health Office keeps several **over-the-counter medications** for use as needed when deemed necessary by the School Nurse. If given, parents are notified by phone, text or a note from the School Nurse. **Parents can give permission for administration of the following medications by checking the boxes and signing below:**

▢ Acetaminophen (Tylenol)
▢ Ibuprofen (Motrin, Advil)
▢ Diphenhydramine (Benadryl)
▢ Calcium Carbonate (TUMS)
▢ Antibiotic Ointment (for cuts/scrapes)
▢ Anti-itch cream (may contain hydrocortisone)
▢ Cough Drop/Throat Lozenges
▢ Vaseline or Lip Balm
▢ Cetirizine (Zyrtec)

Parent/Guardian Signature : ____ **Date:**________________________

In the case of my child suffering life-threatening or potentially life-threatening injuries or illness while at school or a school-related event, I hereby acknowledge and understand that Excel Academy staff shall notify appropriate emergency responders to treat and take my child to a hospital, doctor, or dentist without my additional prior consent. I also release Excel Academy Charter School and its employees, trustees, contractors, volunteers, or agents from any and all liability arising from their acts or omissions related to these notifications and treatment.

Parent/Guardian Signature: ____ **Date:** ______________________

I authorize Excel Academy Charter School (including School Nurses, School Nurse teachers, or other authorized and qualified staff) **to test my student or legal charge for COVID-19**. I understand that this testing may occur multiple times. I understand that COVID-19 testing may create protected health information and other personally identifiable information of the student, and such information will only be accessed, used and disclosed in accordance with HIPAA and applicable law. I authorize Excel to transmit such PHI to the Department of Public health and the Executive Office of Health and Human Services, as authorized under HIPAA. This authorization will remain in full force and effect unless and until such time as I contact the school to revoke this authorization, such revocation to be provided in writing. By signing this form, I am attesting that I have the requisite legal authority and power to make the decisions for, and on behalf of, the student named above.

Parent/Guardian Signature: ____ **Date:** ______________________

PLEASE RETURN THIS COMPLETED FORM, PHYSICAL EXAM FORM AND IMMUNIZATION RECORDS TO YOUR CHILD'S SCHOOL

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