Box Elder School District
Dr. Martell Menlove, 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:

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

☐ **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** ☐ **I do not wish to be contacted**

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