HAMILTON COUNTY EDUCATIONAL SERVICE CENTER

STUDENT HEALTH HISTORY UPDATE

STUDENT _____ **GRADE** _____ **ROOM** _____

Please complete this form and return it to school as soon as possible. Having up-to-date health information allows better care and understanding of your child's needs if problems arise during the school day. If there are any future changes in your child's health status, please call the school nurse at 513-451-7207 or send a note to school. **Check all health conditions your child may have.**

☐ **ADD / ADHD**

☐ **ALLERGIES** or reactions to: (Please explain)

Food(s) _____
Medication(s) _____
Plant / Animal / Environmental / Seasonal_____
_____
_____

☐ **ASTHMA** (Identify triggers)

_____
_____

Has your child ever needed emergency treatment for asthma?
___ YES ___ NO

☐ **BLADDER PROBLEMS** (Please explain)

_____

☐ **BOWEL PROBLEMS** (Please explain)

_____

☐ **CYSTIC FIBROSIS**

☐ **DIABETES** Age of diagnosis _____

☐ **EAR INFECTIONS** (frequently after age of 3)

Approximate date or age of last infection _____
Currently under the care of ENT? ___ YES __ NO
Currently has PE tubes? ___ YES ___ NO
Date of last ENT appointment _____

☐ **EATING DISORDER**

☐ **EMOTIONAL/ BEHAVIORAL CONCERNS**

☐ **EYE PROBLEMS** (Please explain)

_____
Wears glasses/contacts? ___ YES ___ NO
Date of last eye examination _____

☐ **HEADACHES** (frequent)

Migraines? ___ YES ___NO

☐ **HEART CONDITION** (Please explain)

_____

☐ **KIDNEY DISEASE** (Please explain)

_____

☐ **MENSTRUAL PROBLEMS** (Please explain)

_____

☐ **PHYSICAL DISABILITY** (Please explain)

_____
_____

☐ **RECENT HOSPITALIZATION/SURGERY**
SIGNIFICANT INJURY (Please explain)

_____

☐ **SICKLE CELL DISEASE** (not trait)

Date of last sickle cell crisis _____

☐ **SEIZURES / EPILEPSY**

Date of last episode _____

☐ **SPINAL CURVATURE** (scoliosis, etc.)

Currently under the care of an orthopedic doctor?
___ YES ___ NO

☐ **TICS / NERVOUS TWITCHES**

My child takes the following daily medication(s) _____
My child takes the following medication(s) occasionally _____
Please identify any other health information not listed above that you believe school personnel need to be aware of_____
_____

☐ **NONE OF THE ABOVE APPLIES TO MY CHILD.** This information may be shared with school personnel if it is pertinent to health and safety, educational progress and/or behavioral management plan.

Parent/Guardian Signature_____ **Date** _____

2023 - 2024 EMERGENCY MEDICAL AUTHORIZATION

this form must be filled out and returned on or before the first day of school

SCHOOL DISTRICT: Archdiocese of Cincinnati

SCHOOL ATTENDING: **Our Lady of the Visitation**

(PLEASE PRINT):

STUDENT'S LAST NAME _____ STUDENT'S FIRST NAME_____

DATE OF BIRTH _____ GRADE _____ HOMEROOM TEACHER_____

HOME ADDRESS _____ HOME PHONE _____

MOTHER'S NAME _____ FATHER'S NAME _____

MOTHER'S CELL _____ FATHER'S CELL _____

MOTHER'S EMAIL _____ FATHER'S EMAIL _____

In the event of an emergency or to verity the absence of my child from school (if the school has not been notified by 8:30 a.m.) PLEASE CONTACT:

1. _____ _____ _____ _____
   Name Relation Phone # Email Address

2. _____ _____ _____ _____
   Name Relation Phone # Email Address

2. _____ _____ _____ _____
   Name Relation Phone # Email Address

PART I OR II MUST BE COMPLETED
PART 1 TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name _____ Phone # _____

Dentist's Name _____ Phone # _____

Local Hospital _____ ER Phone #_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____ _____
Date Signature of Parent or Guardian Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I
PART II

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

_____ _____ _____
Date Signature of Parent or Guardian Address

PLEASE COMPLETE OTHER SIDE