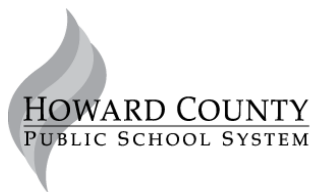

SCHOOL HEALTH SERVICES
MEDICAL CONDITION HISTORY RECORD

DATE ________________________________

To The Parents/Guardian of ____________________________ Grade _______ Date of Birth ______________

Our records indicate that your child has the following health condition/concern: __________________________

____

In order for school personnel to respond to this health concern quickly and effectively, additional information concerning this condition would be helpful. The information you supply will be kept confidential and shared with staff on a need-to-know basis.

More information about this will help us to care for your child at school. Please answer the following and circle where applicable:

1. What are the usual symptoms? ____

   ____

2. How do you treat this at home? ____

   ____

3. Does this condition ever result in an emergency for your child? ________________________________

   ____

4. Will medication need to be taken in school? YES NO

   The Howard County School System does not encourage the routine administration of medication in the school setting. However, if medication is necessary at school, a written health care provider's order and signed parent permission are required to be on file in the health room. Please consult with the health assistant or school nurse for forms and further information.

5. Are there any restrictions or limitations? YES NO

   If yes, describe:____

   If your child requires activity restrictions, HCPSS form 39513040- Physical Education / Activity Assessment Form, must be completed annually, by the health care provider, in order to be excused from certain curriculum.

6. Do you give permission for school personnel to contact the student's health care providers? YES NO

Pediatrician's Name ______________________ Phone ______________

Specialist's Name ______________________ Phone ______________

PARENT SIGNATURE ______________________ **Date** ______________

Please share any **ADDITIONAL INFORMATION** with the School Nurse and Health Assistant below:

____

____

____

Would you like to be contacted by the School Nurse? YES NO

Contact Name ____

Contact Number ______________________ Best Time to Contact ______________

HEALTH ROOM USE ONLY

Form **Received** –Date: ______________	Form **Reviewed** –Date: ______________
Signed: ______________	Signed: ______________