Bentonville Schools

Student Health History

Student Name: Date of Birth: _____ Grade: ___ Teacher:

Parent/Guardian Name (Print):_____ Phone:_____

Parent/Guardian Name (Print):_____ Phone:_____

Emergency Contact: _____ Phone#: _____

Emergency Contact: _____ Phone #:

Primary Email: _____ Secondary Email: _____

Doctor: _____ **Hospital**: _____ **Insurance**: Private____ Medicaid/AR Kids ___

Medically Diagnosed Conditions	Current	Past (Year)	Never	Medically Diagnosed Conditions	Current	Past (Year)	Never
***ADD/ADHD**				Heart Condition / Heart Surgeries			
***Asthma**				High/low blood pressure – blood issues			
Balance issues; leg braces, wheelchair, etc.				Intestinal Issue/Constipation/Encopresis			
***Diabetes** or Sugar in urine				Loss of family, divorce/separation, move			
Dizziness or Fainting spells				Seasonal Allergies, hay fever			
Dyslexia (include medical documentation)				**Severe behavioral issues**			
Eczema, Skin disease				***Severe Allergies (Requires Epi-Pen)**			
***Epileptic** seizures / convulsions				Severe or Chronic Abdominal Pain			
Eye trouble				Severe Head injury / Concussion			
Frequent ear infections / Ear tubes				Tumor, Growth, or **Cancer**			
Frequent or Painful Urination				Wears Glasses/Contact lenses			
Frequent, Severe Headache				Wets or Soils Pants day or night			
Hearing loss / Hearing aids				Worry, anxiety/depression, sleep issues			

Asthma, Diabetes, Anaphylaxis, or Seizure Plans require a new health plan yearly. See school nurse for forms

Explain health conditions or concerns: _____

_____

Has your child received recent immunizations: Y N Filed for Arkansas Immunization Exemption? Date: _____ **Give copy to RN**

List any medication your child takes regularly/daily at home:

Medication	**Dosage & Frequency**	**Purpose**	**Side Effects**

List any Allergies to *foods and medications (Rx and over the counter):

Allergy: Reaction: *Recommended Medication: Benadryl: Epi-Pen:

Allergy: _____ Reaction: _____ *Recommended Medication: Benadryl: ___ Epi-Pen: ____

Check SCREENINGS you DO NOT want for your child: ____BMI (K,1,2,4,6,8,10) ____Scoliosis (Girls -6&8 and Boys-8)

Over the counter medications and emergency Epinephrine are available to your child per nurse's assessment. Dosages are based on label instructions and are approved by Dr. Curtis Hedberg. **If your child needs any scheduled prescription or non-precription medications during the school day, a parent or guardian MUST bring medication to the nurse in the original container, ALONG WITH written prescribed orders by an Arkansas Licensed Healthcare Professional.** I hereby authorize any/all medical providers of the Student, for which I am the parent or legal guardian, to confer with and/or release information and records regarding said Student's health care to any representative of the Bentonville School District requesting such information and records.

Parents/Guardians must sign this consent below in order for over the counter medication to be given.

Parent/Guardian Signature: **Date:**

****Office use only****

504:_____ IHP: _____ Processed by: _____Date:_____