HEALTH HISTORY

This form is designed to meet the needs of individual children in our program. This is best accomplished by mutual planning by the parents and staff at the time of admission, as well as ongoing communication throughout each child's participation in the program. South Bay Union School District and community partners do not maintain health insurance for injuries to the participant that may arise from involvement in our before and after school programs.

Name of Child: ______________________________ ❑ Male ❑ Female

Does father live in home with child? ❑ Yes ❑ No   Does mother live in home with child? ❑ Yes ❑ No

Emergency Information:

Family Physician ____________ Address ____________ Phone (____) ____________

Medical Provider Name____________ Child's Medical Record Number ____________

Does your child have any medical conditions or allergies? If so, please list: ____________

Date of last physical/medical examination:____________

If your answer is "Yes" to any of the following questions in Section I through V, please complete a Service Plan Form.

Section I. **BEFORE & AFTER SCHOOL CARE**

❑ Yes ❑ No Is there a problem with your child participating in physical activities?

❑ Yes ❑ No Is there a problem with your child being transported on field trips without special equipment?

Section II. **SNACKS AND MEALS (The District's Wellness Policy is strictly enforced at the Program.)**

❑ Yes ❑ No Does your child have allergies to certain foods?

If yes, please complete a medical statement and return to school site Health Clerk.

List foods: ____________

❑ Yes ❑ No Does your child have allergies to medications or drug reactions?

List medications: ____________

Section III. **MEDICATION (Adhering to District policy, the staff does NOT administer medication.)**

❑ Yes ❑ No Does child take prescribed medication? If yes, what kind and any side effects?

____

❑ Yes ❑ No Does special apparatus need to be used to administer this medication? If so, what?

____

Section IV. **IS YOUR CHILD SUBJECT TO:**

❑ Yes ❑ No Colds

❑ Yes ❑ No Sore throat

❑ Yes ❑ No Fainting spells

❑ Yes ❑ No Bronchitis

❑ Yes ❑ No Convulsions

❑ Yes ❑ No Cramps

❑ Yes ❑ No Allergies

Section V. **DOES YOUR CHILD HAVE OR HAS EVER HAD:**

❑ Yes ❑ No Heart trouble

❑ Yes ❑ No Asthma

❑ Yes ❑ No Lung trouble

❑ Yes ❑ No Sinus trouble

❑ Yes ❑ No Hernia (rupture)

❑ Yes ❑ No Appendicitis

❑ Yes ❑ No Appendix been removed

Is there a medical diagnosis for the conditions that require accommodation?____________

Parent's evaluation of child's personality: ____________

How does the child get along with parents, brothers, sisters, and other children? ____________

Does the child have any special problems/fears/needs? (Explain) ____________

Has this child ever received any special education services during the regular school day? (Example: IEP or 504 Plan) ❑ Yes ❑ No

If yes, please describe the services provided for the child? ____________

What is the primary language spoken in the child's home? ____________

Print Parent/Guardian Name	Parent/Guardian Signature	Date

Health History Form return at registration (1 per student)   Updated: 3/15/18