Health History

Coventry High School Alan Shawn Feinstein Middle School

Dear Parents: Please complete the following forms for your student. This information will be treated as confidential and may be returned in a sealed envelope to the school nurse. This updated information will assist the nurse in addressing the changing health needs of your child.

Name_____ DOB_____ Sex___ Grade_____ Team_____

Please check, list, explain and/or date all that apply:

- ☐ Allergies:_____
- ☐ Asthma:_____
- ☐ Attention Difficulties:_____
- ☐ Diabetes:_____ Type 1☐ Type 2 ☐
- ☐ Lyme Disease:_____
- ☐ Mononucleosis:_____
- ☐ Strep Throat:_____
- ☐ MRSA Infection:_____
- ☐ Headaches:_____
- ☐ Migraines:_____
- ☐ Seizures:_____
- ☐ Anxiety:_____
- ☐ Depression:_____
- ☐ Substance Abuse:_____
- ☐ Anger Issues:_____
- ☐ Eating Disorder:_____
- ☐ Other Mental Health Issues:
  _____
- ☐ Gastrointestinal:_____
  _____
- ☐ Ulcers:_____
- ☐ Weight Problems:_____
- ☐ Menstrual Problems:_____

- ☐ Heart Disease:_____
- ☐ Urinary Tract Infections:_____
- ☐ Kidney Problems:_____
- ☐ Musculoskeletal:_____
  _____
- ☐ Pain:_____
  _____
- ☐ Medications:_____
  _____
  _____
- ☐ Hospitalizations:_____
  _____
  _____
- ☐ Injuries:_____
  _____
  _____
- ☐ Other concerns:_____
  _____
- ☐ _____
  _____

Doctor's Names:

_____

_____

Parents - please complete both sides of this form:

Parent Signature:_____ Date:_____

Standing Orders for Medication at School

The School Nurse, with signed parental permission updated yearly and an updated health history, may administer the following over-the-counter medications to students during school. Please indicate which medications you feel are appropriate for your student. The following medications will not be administered at school without this form on file in the Nurse's Office. Frequent student use of these medications at school, as defined in Section III-C-2-h of Policy #8144 (Student Welfare/First Aid and Medication), may require a doctor's order. Doctor's orders are required for all prescription medications given at school; as well as other over-the-counter medications that are not on this list.

Please check all that are appropriate:

☐ Acetaminophen - 325 mg ☐ 1 tablet OR ☐ 2 tablets
OR
☐ Ibuprofen - 200 mg ☐ 1 tablet OR ☐ 2 tablets
(Headache, menstrual cramps, orthodontic adjustment/pain or musculoskeletal pain.)

☐ Antacid ☐ 1 tablet OR ☐ 2 tablets
(heartburn or indigestion)

☐ Benadryl – 25 mg
(for minor allergic reaction)

☐ A throat lozenge for minor sore throat pain and cough:
Administer one dose every 2 hours for sore throat
Administer one dose every 1 hour for cough

_____ _____
Parental Signature Date

Please list the names of **relatives and/or friends** you authorize to take your child home:

Emergency Contacts:	**Relationship**	**Telephone Number**
1.		
2.		
3.		
4.		

Transfer students - please indicate name and full address of last school attended:

_____

Parents – please complete both sides of this form.