Academy of Arts and Knowledge

Creating an environment in which all students can reach their full potential

4800 Wheaton Drive, Fort Collins, CO 80525 Phone (970) 226-2800

Health History 25-26 School Year

Student's Name: ______________________ **DOB:** ______________
Teacher: ______________________________ **Grade:** ____________
Parent/Guardian Name: __________________ **Contact #:** ____________
E-mail: ____

IDENTIFYING INFORMATION:

Child lives with: ☐ Both Parents ☐ Mother ☐ Father
☐ Other: ______________________

Health Coverage: ☐ Medicaid ☐ CHP+ ☐ Private ☐ None

Primary Health Care Provider: ______________________

Location: ______________________ Phone: ____________

Date of last physical: ____________

Date of last visit: ____________ Reason for visit: ____________

Dental Provider: ______________ Date of last dental exam: ________

Gender assigned at birth: ☐ Male ☐ Female

Preferred Pronouns: ☐ He/him ☐ She/her ☐ They/them

DEVELOPMENTAL HISTORY	Yes	No	Comments
Did your child crawl by 9 months?			
Did your child walk by 18 months?			
Did your child say words by 15 months?			
Was your child toilet trained by 3-1/2 years old?			
Were there problems with balance or coordination?			
Were there problems with fine motor skills? (buttons, handwriting, picking something up)			
Do you have other concerns about your child's development? (If yes, please explain)			
Additional Space for Comments:			

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MEDICAL HISTORY: Please check all that apply

☐ **ADHD/ADD** ☐ Check if medication taken at school.
Medication Authorization Form

☐ **Allergies** ☐ Please mark if allergies are **SEVERE**
EpiPen at School? ☐ YES ☐ No

☐ Environmental
- ☐ Pollen ☐ Dust Mites
- ☐ Air Quality ☐ Insect Bites/Stings
- ☐ Mold ☐ Animal Dander
- ☐ Other: ______________________

☐ Latex
☐ Food allergies: ______________
____
____
(please list all foods)

Allergy/Anaphylaxis Care Plan Medication Authorization Form
☐ Meal Modification Form – student's that will eat school lunch.

☐ **Asthma** ☐ Check if medication taken at school.
☐ **SEVERE** asthma symptoms possible.

Known Triggers:
- ☐ Exercise
- ☐ Illness
- ☐ Weather Changes *(cold air, humidity)*
- ☐ Irritants *(smoke, strong scents)*
- ☐ Stress/Anxiety
- ☐ **LINKED TO Allergies** *(listed above)*

Asthma Care Plan Medication Authorization Form

☐ **Autism** ______________________
☐ **Behavior Disorder** ______________________
☐ **Bleeding Disorder** ______________________
☐ **Developmental Disorder** ______________________

☐ **Diabetes:** ☐ Type 1: Insulin Dependent Date of Diagnosis:
Diabetes Individual Health Care Plan

☐ **Emotional Disorder** ______________________
☐ **Frequent Illness** ______________________
☐ **Genetic Disorder** ______________________

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Student's Name: ______________________ **DOB:** ______________

☐ **Hearing/Ear Disorder** ______________________

☐ **Heart Condition** ______________________

☐ **Neuro Disorder** *(migraines)* ______________________

☐ **Seizure Disorder**

Medication Authorization Form

Seizure Action Care Plan

☐ **EMERGENCY** RESCUE MEDICATION

____

Name of Medication

____

Route of Administration

☐ **Speech Disorder** ______________________

☐ **Vision/Eye Disorder** ______________________

- ☐ Requires glasses/contacts
- ☐ Glasses/contacts for reading only
- ☐ Wear glasses/contacts at school
- ☐ Under care of Eye Care provider

☐ **OTHER:** *Please use the space below for anything pertinent to your student's safety and well being at school that was not covered above.*

____

____

____

**Links to all pertinent/related documentation is linked in each section. AAK Medication Policy requires a Medication Authorization Form for EACH medication your student may need during the school day.*

MEDICATIONS: (over the counter, vitamins, supplements and/or prescription)

Does your student take any daily medications? *(please list all below with dosing/frequency)*

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

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Student's Name: ______________________ **DOB:** ______________

ILLNESSES, HOSPITALIZATION, SURGERIES, AND/OR ACCIDENTS:
Major Illness: ______________________________

____

____

____

Hospitalizations/Surgeries: ______________________________

____

____

____

Accidents/Injuries: ______________________________

____

____

____

GASTROINTESTINAL/URINARY:
Difficulty going to the bathroom? ______________________________

____

____

If specific toileting needs/assistance may be required at school, please provide a letter from your students' provider outlining specific needs (details about assistance, frequency, necessary diagnoses information).

- ☐ Bedwetting ☐ Constipation ☐ Difficult to train
- ☐ Frequent stomach aches ☐ Reflux/indigestion issues
- ☐ Enteral Feeding: G-Tube Feeding Care Plan

PHYSICAL LIMITATIONS/DISABILITIES:

- ☐ Restrictions on activities: ______________________________
- ☐ Adaptive equipment: ______________________________
- ☐ Fatigue easily/poor endurance: ______________________________

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Student's Name: ______________________________ **DOB:** ____________________

Parent Acknowledgement of Medical Information
I acknowledge that I have shared medical information regarding my child, ______________________ *(student's name)*, with school nurse/health office. I understand that this information will be used to help support my child's health, safety, and educational needs during the school day. I give permission for relevant staff to be informed, as appropriate, to provide safe and effective care for my child at school. This information is true and accurate to the best of my ability.

I understand that my child's medical information will be kept confidential in accordance with school policy and applicable privacy laws.

____ ____________________
Parent/Guardian Signature **Date**

Reviewed by School Nurse/CCHC
Name: ______________________________________ **Date:** ____________________

Signature: ____