SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
HEALTH HISTORY INFORMATION

Student: _____ **DOB:** _____ **Grade:** ____ **School:** _____

The above student has the following condition(s):

1. _____
2. _____
3. _____

Please provide us with the following information so that we may have a better understanding of your child's needs while at school.

1. Is your child under the care of a physician for the above condition(s): Yes/No
2. Has your child had a problem with this condition in the last year? Yes/No
   Physician's name: _____ ***Phone #:*** _____
3. Should your child's activities at school be restricted in any Way? (Please explain) Yes/No
   _____
   _____
4. Does your child taken medication for this condition? Yes/No
   Name of medication*:* _____ Dosage*:* _____
   Name of medication*:* _____ Dosage*:* _____
   Name of medication*:* _____ Dosage*:* _____
5. What action do you want the school to take when your child is sent to the Health Office for a problem?
   _____
   _____
6. Please list any other information that might be helpful in caring for your child.
   _____
   _____
   _____
   _____

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION: I authorize the school nurse to communicate with the physician when necessary. I hereby give my permission for exchange of confidential information contained in the record of my child.

Parent Signature: _____ **Date:** _____

Reviewed by Health Services _____ **Date:** _____