Helena Public Schools

Health History

School Year_____

Name		Date of Birth
Gender	School	Grade/Teacher
Physician	Dentist	

The school district considers this to be personal, confidential information that will be treated in a discreet manner. The form may be reviewed by the school nurse, the classroom teacher, the building administrator, and other educators on a need to know basis.

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTH CARE PROVIDER WITH ANY OF THE FOLLOWING:

Health Condition	Yes	No	Explanation if "Yes"
Allergies **Bee Stings** **Food Allergies** **Other**	☐ ☐ ☐	☐ ☐ ☐	**Does your child require an EpiPen? Yes ☐ No ☐** **List: EpiPen? Yes ☐ No ☐** **List: EpiPen? Yes ☐ No ☐**
ADD/ADHD	☐	☐	**Medication:**
Asthma	☐	☐	**Asthma medication taken at home:** **Medication required at school:**
Autism Spectrum Disorder	☐	☐	**Describe:** **Verbal ☐ Non Verbal ☐ Medications:**
Bowel/Bladder Issues	☐	☐	**Describe:**
Diabetes	☐	☐	**Type 1 (insulin dependent) ☐ Type 2 ☐** **Diabetes medications:**
Hearing Loss	☐	☐	**Right Ear ☐ Left Ear ☐ Hearing Aids ☐**
Heart Condition	☐	☐	**Describe:**
Mental Health/Emotional/Behavioral	☐	☐	**Describe:** **Medication/Treatment:**
Seizure Disorder	☐	☐	**Type of Seizure: Medications:**
Serious Injury	☐	☐	**Describe:** **Dates:**
Surgery	☐	☐	**Describe:** **Dates:**
Vision	☐	☐	**Glasses ☐ Contacts ☐ For Distance ☐ For Reading ☐**

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Other	☐	☐	**Describe:**
Please list medications taken at Home if not already listed: **Medication**			**Dose** **How often** **Reason**

Medications

Helena School District requires written permission from a Health Care Provider and parent/guardian before prescription or over-the-counter medication can be given to students K-8 grades at school. For High School students written permission from a Health Care Provider and parent/guardian must be provided for administration of prescription medications only. School Nurses **do not** have over-the-counter medications (Tylenol, Ibuprofen, Tums) to give to students. An *Authorization for Medications to be Given at School* form is available from your School Nurse or from the Helena School District website https://helenaschools.org/departments/health-services/

_____ _____

Parent/Guardian Signature **Printed Name** **Phone**

imMTrax Consent Form for Children

Child's Name:_____ Sex: M☐ F☐ Date of Birth:_____

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

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Parent/Guardian Signature **Date**