

MEDICAL HISTORY

This form is to be completed by parents and returned to the school promptly. This form will assist the school health coordinator and staff to provide for the needs of the student throughout the year. All students are required to have a medical examination by a physician on file. A student's medical file is not complete without the Medical History, Medical Exam Report, Immunization Record, Designation of Representation and Health Insurance information.

Medical information from the parents of: _____
(Student's Name)

(Parent name/s) (Address) (City, State, Zip)

Home Phone: (_____) _____ Business Phone: (_____) _____

Student's Birth Date: _____ Student's Social Security Number: _____

Is the student covered by your medical insurance? Yes ___ No ___ (See attached insurance information form.)

Is the student subject to any frequent illness? Yes ___ No ___

Please describe the illness and note the normal home treatment: _____

DISEASES: Please check any of the following diseases which the student has had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Infantile Paralysis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps |

Any others: _____

VACCINATIONS: The following immunizations are required for all students who are enrolled in Iowa schools. Please enter the date that all the following immunizations were given. Note that the first dose of the MMR vaccine must have been received after 12 months of age.

REQUIREMENTS FOR SCHOOL ENTRY:

Diphtheria-Tetanus-Pertussis (DTP or DTaP): 3 doses required, at least one dose on or after age 4

Polio: 3 doses required, at least one dose on or after age 4

Measles -Rubella: 2 doses required if enrolled after July 3, 1991; 1 dose required if enrolled before July 3, 1991

Hepatitis B: 3 doses required if born on or after July 1, 1994

DTP / DTaP	Dose 1 _____	Dose 2 _____	Dose 3 _____
Polio	Dose 1 _____	Dose 2 _____	Dose 3 _____
MMR	Dose 1 _____	Dose 2 _____	
Hep B	Dose 1 _____	Dose 2 _____	Dose 3 _____
Tetanus	Date of last shot _____	Hib _____	Varicella _____

ALLERGIES: Please list all of your student's allergies, including medications and foods.

PLEASE COMPLETE REVERSE SIDE

AUTHORIZATIONS: If this student develops or is exposed to any disease which is most satisfactorily prevented or treated by the use of serum, vaccine, or antitoxin, do you authorize the school to have these given at your expense?

Yes: _____ No: _____

If an acute condition should develop, do you authorize the school to place the student in an Iowa City hospital?

Yes: _____ No: _____

OTHER:

Has the student ever smoked regularly? Yes ___ No ___

Used hallucinatory drugs? Yes ___ No ___

Received psychiatric/psychological counseling? Yes ___ No ___

Describe: _____

Is the student bringing any prescription drugs to school? Yes ___ No ___

Name of drug & condition it is used to treat, and length of time on this medication: _____

We are required to keep all prescription drugs in the health office. Please notify the health coordinator of any prescription drugs your child will bring to the school. Also, please include all necessary prescriptions, including eyeglass prescriptions.

Do you have any special requests for the school in caring for the health of your student? _____

PARENT SIGNATURES: I/We verify that the information contained on this form is correct to the best of my/our knowledge. I/We will contact the school with changes as they occur.

(Signature of Parent or Guardian)

(Date)

(Signature of Parent or Guardian)

(Date)