Happy Valley School

7140 W. Happy Valley Road
Peoria, Arizona 85383
(623) 376-2900 * Fax (623) 376-9030

★Character ★Leadership ☆Academic Success

Confidential Health History
School Year 2020-2021

IF NO changes to your child's health history, you DO NOT need to fill out this form. Fill out first box below (name/grade, etc.). Sign and date here:_____Date:_____

Student Last Name:	First Name:	Middle:	Grade Level Entering:
Address:	City:	Zip:	Date of Birth:

Please check all that apply, enter information regarding any health issues that needs to be discussed with the school nurse and your child's teacher, and indicate if your child is under a physician's care.

VISION/HEARING/SPEECH

Wears Glasses: ☐Yes ☐No	Date of Last Eye Exam:	Describe Any Speech Related Problems:
Wears Contacts: ☐Yes ☐No	Other Eye Problem:	
For Distance: ☐Yes ☐No	Hearing Loss: ☐Yes ☐No	
For Reading: ☐Yes ☐No	Hearing Aid: ☐Yes ☐No	
Color Blind: ☐Yes ☐No		

ALLERGIES

Environmental: ☐Yes ☐No	Medication: ☐Yes ☐No	Other: ☐Yes ☐No
List:	List:	List:
Food: ☐Yes ☐No	Insect Stings: ☐Yes ☐No	Epipen: ☐Yes ☐No
List:	List:	

STUDENT HEALTH HISTORY

ADD:	☐Yes	☐No	Emotional/Psychological Concerns:	☐Yes	☐No
ADHD:	☐Yes	☐No	Describe:		
Anemia:	☐Yes	☐No	Head Injury/Concussion:	☐Yes	☐No
Asthma:	☐Yes	☐No	Heart Condition:	☐Yes	☐No
Inhaler at School:	☐Yes	☐No	Describe:		
SVN Treatment at School:	☐Yes	☐No	Hemophilia:	☐Yes	☐No
Bronchitis:	☐Yes	☐No	Hepatitis or Liver Problem:	☐Yes	☐No
Pneumonia:	☐Yes	☐No	Hernia:	☐Yes	☐No
Other Respiratory Problems:	☐Yes	☐No	High Blood Pressure:	☐Yes	☐No
Describe:			Juvenile Arthritis:	☐Yes	☐No
Blood Disorder:	☐Yes	☐No	Neurological Condition:	☐Yes	☐No
Describe:			Describe:		
Cancer:	☐Yes	☐No	Neuromuscular Condition:	☐Yes	☐No
Type:			Describe:		
Chicken Pox:	☐Yes	☐No	Nosebleeds:	☐Yes	☐No
Cystic Fibrosis:	☐Yes	☐No	Frequency:		
Diabetes:	☐Yes	☐No	Scoliosis:	☐Yes	☐No
Glucose Monitoring:	☐Yes	☐No	Seizure Disorder:	☐Yes	☐No
Ear Infections:	☐Yes	☐No	Describe:		
Ear Tubes:	☐Yes	☐No	Sickle Cell Anemia:	☐Yes	☐No
Eczema:	☐Yes	☐No	Strep:	☐Yes	☐No
Psoriasis:	☐Yes	☐No	Urinary/Bladder/Kidney Condition:	☐Yes	☐No
Other Skin Conditions:	☐Yes	☐No	Describe:		

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DOB:

STUDENT HEALTH HISTORY (continued):
Any Dietary Restrictions:
Please List Surgeries/Hospitalizations and Dates:
List All Medications Your Child Is Taking:
Will Medications Be Taken At School? Yes☐ No☐ Medication Is For?
OTHER HEALTH PROBLEMS:

- ✓ *All medications must be brought to school by an adult in the original prescription container with dosages and instructions, physician's name and telephone number, expiration date, etc.*
- ✓ *A parent-signed consent form for administration of medication at school must be on file with the nurse.*
- ✓ *Students may not have medications of any kind in their possession at school at any time.*

Are your child's immunizations up-to-date? ☐Yes ☐No

Immunizations must be current by August 31st or the first day of school attendance. Please see the list of required immunizations and schedule on the Maricopa County Department of Public Health website or call (602) 263-8856 for requirements and free clinic hours.

I certify that the information above and all health-related information is correct, current and complete.

Print Name: _____ Parent Signature: _____

Date: _____