



# HAPPY VALLEY SCHOOL

7140 W. Happy Valley Road Peoria, AZ 85383  
(623) 376-2900 (623) 376-9030 fax www.happyvalleyschool.org

★ CHARACTER ★ LEADERSHIP ★ ACADEMIC SUCCESS

## Confidential Health History School Year 2023-2024

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<b>Student Last Name:</b>	<b>First Name:</b>	<b>Middle:</b>	<b>Grade Entering:</b>
<b>Address:</b>	<b>City:</b>	<b>Zip:</b>	<b>Date of Birth:</b>

**NO CHANGES** \_\_\_\_\_ (Stop and complete bottom of page 2)

Please check all that apply, enter information regarding any health issues that need 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Eye Exam:	Describe Any Speech Related Problems:
Wears Contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Eye Problem:	
For Distance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No	
For Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aid: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Color Blind: <input type="checkbox"/> Yes <input type="checkbox"/> No		

ALLERGIES		
Environmental: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No
List:	List:	List:
Food: <input type="checkbox"/> Yes <input type="checkbox"/> No	Insect Stings: <input type="checkbox"/> Yes <input type="checkbox"/> No	EpiPen: <input type="checkbox"/> Yes <input type="checkbox"/> No
List:	List:	

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



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<b>STUDENT HEALTH HISTORY (continued):</b>	
Any Dietary Restrictions:	
Please List Surgeries/Hospitalizations and Dates:	
List All Medications Your Child Is Taking:	
Will Medications Be Taken at School?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 31<sup>st</sup> 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.

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_