mount vernon SCHOOL OF MUSIC

mvschoolofmusic.com

HEALTH HISTORY FORM

Student's Name	Birthdate / /	Age	Sex M F	Grade

Mother/Guardian ______	Father/Guardian ______
Cell Phone: (____)____-______	Cell Phone: (____)____-______
Home Phone: (____)____-______	Home Phone: (____)____-______
Work Phone: (____)____-______	Work Phone: (____)____-______

Name of Physician ______ Phone (____) ____-______

Name of last school attended ______ City/State ______

SPECIAL HEALTHCARE PLANNING/SERIOUS HEALTH CONDITIONS: Please notify the school nurse of a serious or life threatening health condition prior to the start of school.

☐ Allergy/Anaphylaxis: My child has severe allergy/anaphylaxis requiring an Epi Pen/Auvi-Q prescription.
☐ Describe the allergy (food, insect, etc.) ______
☐ Asthma: ☐ Yes ☐ No My child uses rescue inhaler routinely for asthma symptoms.
☐ Yes ☐ No My child has been hospitalized in the past year for asthma.
☐ Yes ☐ No My child has needed steroids (prednisone) for asthma symptoms in the past year.
☐ Diabetes: Date of diagnosis: ______ My student has: ☐ insulin pump ☐ insulin pen ☐ injected insulin
☐ Seizure Disorder: My student needs emergency medication for seizures. Name of medication: ______
☐ Other: My child has special health care needs: wheel chair, tube feedings, breathing tube, catheter, intravenous tubes, other. Please describe your child's condition and healthcare needs: ______

OTHER HEALTH CONDITIONS: Check any condition your child currently has or has had in the past.

☐ ADD/ADHD	☐ Depression/Anxiety	☐ Orthopedic/Bone
☐ Allergies ☐ Seasonal	☐ Dental ☐ Braces/Orthodontia	☐ Serious Injury
☐ Dietary Restrictions	☐ Ear Infections ☐ Ear Tubes	☐ Surgery(s)
☐ Bladder/Bowel	☐ Hearing Impairment ☐ Hearing Aides	☐ Social/Emotional/Behavioral
☐ Blood Disorder	☐ Headaches/Migraines	☐ Stomach Aches
☐ Concussion	☐ Heart Disease	☐ Throat Infections
☐ Cancer	☐ Kidney Disease	☐ Vision: ☐Glasses ☐Contacts

Explain any health condition(s) checked ______
Does your child require any restriction of physical activity in school? ☐ No ☐ Yes, specify nature and duration of restriction:
______

EMERGENCY CONTACT: (if parent/guardian cannot be reached)

1. Name ______ Relationship______ Phone (____)____-______
2. Name ______ Relationship______ Phone (____)____-______

Preferred Hospital ______ City/State ______

Statement of Consent:

In order to better serve the healthcare needs of my child, I give my permission for the transfer of health information to the Mount Vernon School of Music and any other appropriate school or healthcare professionals including emergency personnel.
I authorize Mount Vernon School of Music personnel to obtain emergency medical care for my child in the event I cannot be reached.

Print Parent/Guardian Name	Signature of Parent/Guardian	Date / /