Canutillo Independent School District
Student's Medical History

Student Name:	**Student ID:**
Date of Birth:	**Sex:**
Grade:	**Campus:**

1. Does the student have any health problems? (If "Yes", please describe below.	☐ Yes ☐ No
If "Yes", state age of onset and description:	
2.Has the student ever been hospitalized for a serious illness, operation, or psychiatric/mental evaluation?	☐ Yes ☐ No
If "Yes", give age and reason for hospitalization or operation.	
Reason:	Age:
Reason:	Age:
3. Has the student had any serious injuries (such as concussion, fracture, car accident, etc.)?	☐ Yes ☐ No
If "Yes", give age and description of injury.	
Injury:	Age:
Injury:	Age:
4. Does the Student take any medications regularly?	☐ Yes ☐ No
Medication/Dose/Time	**Reason**

5. If the student has any allergies, please select "Yes" to all that apply and "No" to those that do not apply.		
☐ Yes ☐ No	Medication - Type of reaction and severity:	
☐ Yes ☐ No	Seasonal - Type of reaction and severity:	
☐ Yes ☐ No	Food - Type of reaction and severity:	
☐ Yes ☐ No	Other - Type of reaction and severity:	
6. If the student has ever had any of the following, please select "Yes" and indicate the age when it was first diagnosed. If none apply, select "No". Please write in any medical problem that is not listed in "other".		
☐ Yes ☐ No	ADD/ADHD	Age:
☐ Yes ☐ No	Mental Health/Emotional Problems	Age:
☐ Yes ☐ No	Asthma	Age:

☐ Yes ☐ No	Diabetes	Age:
☐ Yes ☐ No	Heart Problems	Age:
☐ Yes ☐ No	Seizures/Epilepsy	Age:
☐ Yes ☐ No	Headaches	Age:
☐ Yes ☐ No	Gastrointestinal /Urinary	Age:
☐ Yes ☐ No	Other:	Age:
☐ Yes ☐ No	Other:	Age:

7.Please answer "Yes" or "No" to the following.

☐ Yes ☐ No	Wears glasses/contact lenses (Please type month and year oflast eye exam below and indicate ifthey are currently lost or broken. below.) Month/Year: Lost ☐ Broken ☐
☐ Yes ☐ No	Uses hearing aid/auditory trainer (Please type month and year oflast audiological exam and indicate ifthey are currently lost or broken. Month/Year: Lost ☐ Broken ☐
☐ Yes ☐ No	Needs special procedures performed by the school nurse. (Please indicate all that apply. Toileting ☐ Diapering ☐ Feeding ☐ Other:
☐ Yes ☐ No	Uses a communication device.
☐ Yes ☐ No	Uses a cane, walker or wheelchair.
☐ Yes ☐ No	Student has a 504 plan or Special Education Plan (Individualized Education Plan, IEP)
☐	By checking this box, I understand that it is my responsibility to inform the school nurse of any current or future medical condition(s).
☐	I certify that this information is true and correct. I understand that presenting a false record or falsifying records is an offense under Section 37.10, Penal Code, and enrollment of a child under false documents subjects the person to liability for tuition or other costs. Texas Education Code Section25.002(d)
Signature:	
Date:	