

**GILBERT COMMUNITY SCHOOLS  
HEALTH HISTORY FOR RETURNING STUDENTS  
\*Please return by the first day of school\***

Student Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Grade: \_\_\_\_\_ Birth date: \_\_\_\_\_ Physician: \_\_\_\_\_

YES NO

- \_\_\_\_ \_\_\_\_ Allergies DESCRIBE: \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ Epipen (if yes, please complete an EMERGENCY ACTION PLAN).
- \_\_\_\_ \_\_\_\_ Needs to sit at a peanut/nut free table for lunch.
- \_\_\_\_ \_\_\_\_ Asthma (LIST INHALER): \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ My student will carry an inhaler to school/school sponsored events.
- \_\_\_\_ \_\_\_\_ My student will be taking daily medication at school.
- \_\_\_\_ \_\_\_\_ Chronic health condition/disease  
DESCRIBE: \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ History of chickenpox.
- \_\_\_\_ \_\_\_\_ Hospitalizations/Surgeries DESCRIBE: \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ Hearing/Visual concern DESCRIBE: \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ Does your student wear glasses/contacts?
- \_\_\_\_ \_\_\_\_ Can your student take Tylenol at school if needed?
- \_\_\_\_ \_\_\_\_ Can your student take Ibuprofen at school if needed?
- \_\_\_\_ \_\_\_\_ Has your student lived outside the USA within the past year?

Other concerns including emotional/behavioral: \_\_\_\_\_  
\_\_\_\_\_

Medication taken on a regular basis:

| Name of medication | Reason for use | Time taken |
|--------------------|----------------|------------|
|                    |                |            |
|                    |                |            |

**All health information is confidential and may be shared only on a professional basis  
with school staff members when necessary.**

\_\_\_\_\_  
Parent/Guardian Signature Phone # Date

\*Please write below and/or on back of the form if needed for further comments.

