



**FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT**  
520 Fifth Ave. Fairbanks, AK 99701 (907) 452-2000

**STUDENT HEALTH HISTORY FORM AND RELEASE OF INFORMATION**

Student \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ [ ] F [ ] M

**MEDICAL CONDITIONS**

***Does your child have any of the following conditions? Check all that apply and explain below.***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Headaches/Migraine        | <input type="checkbox"/> Menstrual Irregularity        |
| <input type="checkbox"/> Behavioral/Emotional Disorder | <input type="checkbox"/> Hearing Loss/Hearing Aids | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Bone/Joint Disorder           | <input type="checkbox"/> Heart Condition           | <input type="checkbox"/> Skin Disorder                 |
| <input type="checkbox"/> Concussion History            | <input type="checkbox"/> History of Scoliosis      | <input type="checkbox"/> Stomach/Intestinal Disorder   |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hyperactivity/ADHD        | <input type="checkbox"/> Vision Loss/Corrective Lenses |
|  | <input type="checkbox"/> Other Conditions _____    |  |

Please explain above concerns:

**ALLERGIES**

Does your child have any significant **allergies** (including food allergies)? [ ] Yes [ ] No

If yes please list allergy(s) and symptom(s) of allergic reaction here:

How is the allergy treated?

My child will require prescription medication administration at school (**Request for Administration of medication and/or Request for Self-Administration of Medication for Asthma/Anaphylaxis required**)

**PERMISSION TO ADMINISTER NON-PRESCRIPTION MEDICATION AT SCHOOL**

Over-the-counter medications, which are on the approved standing orders from the district medical advisor, may be administered to students when the parent/guardian gives written consent and a Registered School Nurse has assessed and deemed necessary in order for the student to maintain participation in school. **Check all that may be administered by the School Nurse and/or designated trained unlicensed staff:**

- |   |   |
|---|---|
| <input type="checkbox"/> Tylenol (acetaminophen)  | <input type="checkbox"/> Benadryl (diphenhydramine) |
| <input type="checkbox"/> Motrin/Advil (ibuprofen) | <input type="checkbox"/> TUMS (antacid)             |

**ACCESS IMMUNIZATION RECORDS**

I \_\_\_\_\_ request and authorize the school nurse/medical staff at Fairbanks North Star  
parent/guardian

Borough School District the access of my above named child's immunization records within the **VacTrAK** system managed by the Epidemiology Section of the Alaska Department of Health and Social Services.

**RELEASE OF INFORMATION**

The disclosure of health information within the school is limited to information necessary to ensure the student's health and educational interests are met. Your signature below gives permission for school staff to be informed of precautions and procedures necessary to protect your child while in school.

**PARENT ACKNOWLEDGMENT**

My signature below is acknowledgment that the information provided is current and correct. I understand that it is my responsibility to notify the school when the information has changed or I no longer give permission to administer medication to my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_