Olathe District Schools
Secondary Health Intake Information

Today's Date: _____ Grade: _____ Information obtained from: _____ (Parent/Guardian)

Student's Name: _____ (Last First MI) Birth Date: _____ Male ☐ Female ☐

Physician: _____ Specialist/Other: _____

Preferred Hospital: _____

Current Medication / Treatment	Dose	Time of day	Reason or Diagnosis

Any development, behavioral or medical concern?

Medical History

Please check yes or no to all, regarding student's medical history.

History	Yes	No	Comments	Medication
Vision correction Vision condition / loss	☐	☐	☐ Glasses ☐ Contact Lenses	
Ear Infections Hearing loss	☐	☐	☐ Currently ☐ Tubes (x____)	
Headaches	☐	☐		
Seizures	☐	☐	Type of Seizure: Date of onset: Date of last seizure:	
ADD or ADHD	☐	☐		
Mental/behavioral Concerns	☐	☐		
Dental concerns	☐	☐		
Allergies	☐	☐	Food _____ Seasonal ☐ Insect Stings ☐ Medication ☐ Reaction: Anaphylaxis:	
Asthma	☐	☐	List triggers?	
Frequent Sinus Infections	☐	☐		
Bronchitis/Pneumonia	☐	☐		(see other side)

History	Yes	No	Comments	Medication
Dizziness/Fainting Holds Breath	☐	☐		
Sleep Disturbances	☐	☐		
Tonsillitis (frequent)	☐	☐		
Nosebleeds	☐	☐	How often?	
Bladder/Kidney Concern	☐	☐		
Urinary Tract Infections	☐	☐		
Stomachache (frequent) Ulcers Irritable bowel	☐	☐	Specify:	
Hospitalizations Surgeries	☐ ☐	☐ ☐	Age/year/reason	
Accidents Head Injury/Concussion	☐ ☐	☐ ☐	Type of accident/age/year	