



TEMECULA VALLEY CHARTER SCHOOL

2026-2027 STUDENT HEALTH HISTORY

Student's Legal Last Name	Student's First Name	Middle Name	Grade	Birth Date
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Please check the appropriate box of any conditions that apply and give a brief explanation in the space provided at the bottom of this form. List all health conditions including those from previous years. Please notify the Credentialed School Nurse at your child's school of any changes in your child's health condition or change of medication.

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| <ul style="list-style-type: none"> <input type="checkbox"/> Allergy – SEVERE <ul style="list-style-type: none"> <input type="checkbox"/> Requires EPIPEN/medication- use form below <input type="checkbox"/> Allergy – Food - Requires Physician order - use form below <input type="checkbox"/> Allergy – Non-Food, List type and symptoms below <input type="checkbox"/> Arthritis – List below <input type="checkbox"/> Asthma – <ul style="list-style-type: none"> <input type="checkbox"/> Requires medication or inhaler- use form below <input type="checkbox"/> Attention Deficit Disorder -ADD/ADHD - use form below <input type="checkbox"/> Autism <input type="checkbox"/> Chromosomal Disorder, list below <input type="checkbox"/> Blood Disorder, list below <input type="checkbox"/> Downs Syndrome <input type="checkbox"/> Cancer - List type <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cleft Palate/Lip <input type="checkbox"/> Confidential Health Problem - Call School Nurse <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes, Type I- Insulin dependent - *Requires meeting with School Nurse* <input type="checkbox"/> Diabetes, Type II – *Requires meeting with School Nurse* <input type="checkbox"/> Eating Disorders/Physician diagnosed <input type="checkbox"/> Endocrine Disorder <input type="checkbox"/> Gastrointestinal Condition, list below <input type="checkbox"/> Growth Disorder, explain below <input type="checkbox"/> Head Injury/Concussion <input type="checkbox"/> Hearing Impairment, list hearing aids if needed | <ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease/Cardiovascular Condition, explain below <input type="checkbox"/> Hemophilia – Call School Nurse <input type="checkbox"/> Hypoglycemia/Physician diagnosed <input type="checkbox"/> Kidney Disorder/Disease, list below <input type="checkbox"/> Medication Taken at Home, list below <input type="checkbox"/> Medication Needed at School - Requires Physician order - use form below <input type="checkbox"/> Migraines/physician diagnosed – list medication <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Muscular - Skeletal Condition <input type="checkbox"/> Neurological Condition <input type="checkbox"/> Nosebleeds – Severe <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Osgood - Schlatter Disease - Required Physician note if activity is restricted - use form below <input type="checkbox"/> Physical Activity Limitations, Requires Physician note <input type="checkbox"/> Seizure Disorder, list medications in form below, describe symptoms <input type="checkbox"/> Diastat - *Requires meeting with School Nurse* - Requires Diastat Physician order <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Other health problems not listed <p><input type="checkbox"/> NO MEDICAL CONDITIONS TO REPORT</p> |
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All medications given at school require a TVCS Medication Authorization Form to be filled out, see form below. Please list any other information regarding above checked conditions:

By signing below, I verify that the information above is accurate and complete.

☆ Parent Signature	Date
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Temecula Valley Charter School

AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION

Name of Student	Date of Birth	Grade	School Year
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Education code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel. If the school district receives (1) a written statement from such physician detailing the method, amount, and timed scheduled by which such medication is to be take, and (2) a written statement from the parent/guardian of the pupil indication the desire that school district assist the pupil in the matter set forth in the physician statement.

- If your physician would like your child to carry either an asthma inhaler or emergency medication (auto-injectable epinephrine) Part III must be completed by the doctor, parent, and child.
- The parent, or adult representative designated by the parent, must bring all prescribed medications to school in its prescription-labeled container.
- Over the counter medications must be brought in an unopened container.
- All medications will be maintained in the Health Office with the exception of medications designated in Part III, as prescribed by the physician.
- Parents / Guardian may pick up unused medications at the close of the school year. Medication remaining after the last day of school will be properly discarded.

NO MEDICATION WILL BE ADMINISTERED WITHOUT REQUIRED SIGNATURES. THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS.

PHYSICIAN AUTHORIZATION

ONE MEDICATION PER FORM

I. PRESCRIBED MEDICATION REQUIRED TO BE ADMINISTERED DURING SCHOOL HOURS (THIS SECTION TO BE COMPLETED BY A PHYSICIAN)

Name of medication	Health condition for which medication is prescribed
Time (s) to be taken	Dosage
Route of Administration	Precaution-possible untoward reactions
Date to be discontinued	Special storage instructions
Name of physician (Please Print)	Physician's telephone and fax numbers
Physician signature	Date

II. THIS SECTION IS TO BE COMPLETED BY THE PARENT / GUARDIAN (PARTS I AND II MUST BE COMPLETED)

I give permission for my child to receive the above medication at school according to the district board policy and administrative regulations, and agree to release, indemnify, and hold harmless Temecula Valley Charter School, officers, agents and employees, from lawsuits, claims, demands, actions, or expenses that may rise against them for administering medication as set forth in accordance with the provision of part I above.

- I agree to allow communication and the exchange of pertinent medication information between medical providers and the Health Clerk and/or District Nurse involved with my child's medical care.
- I understand that I may terminate consent for such administration of medication at any time, in writing.

Signature of Parent / Guardian: _____ Relationship: _____ Date: _____



Temecula Valley Charter School

AUTHORIZATION AND PROTOCOL FOR SELF-ADMINISTERED MEDICATION

Name of Student	Date of Birth	Grade	School Year
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In order for your child to carry a self-administered emergency medication on his / her person, the following must be understood and agreed upon by the student and parents; the student may utilize the prescribed self-administered medication, and is needed and directed by his / her physician. The doctor's signature indicates the student has been instructed on the proper use of the prescribed medication. The medication must be properly labeled with the student's name. **Both the Authorization for Prescribed Medication for and this Protocol** must be signed by the parent / guardian and placed on file at the school prior to your child carrying a self-administered medication on his / her person.

Inhaler: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues to have difficulty breathing he / she should report to the health office and the parents will be notified by the appropriate staff.

Self-Administered Emergency Epinephrine: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for notifying school staff in the event he / she had the need to self-administer the emergency medication.

- It is the parent's responsibility to immediately notify the school if the child's health status changes or when a change in physician and / or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.
- The district is not responsible for any risk involved with improper handling of this medication including overuse, improper administration, breakage, theft, loss, sharing with or careless storage of the medication.
- Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risk of him / her self or the student on campus.

III. PERMISSION TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION AND AUTO-INJECTABLE EPINEPHRINE (i.e. Epi-Pen)

<p>TO BE COMPLETED BY PHYSICIAN: The above-name student has been instructed on the proper use of their asthma inhaler / emergency medication. The child's well-being is in jeopardy unless this medication is carried on his / her person. Therefore, I request that s/he be permitted to carry the asthma inhaler / emergency medication at school. S/he is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the asthma inhaler / emergency medication.</p>	
PHYSICIAN SIGNATURE: _____	DATE: _____
PRINTED NAME OF PHYSICIAN: _____	

<p>TO BE COMPLETED BY PARENT / GUARDIAN: I permit my child to carry the above-listed asthma inhaler / emergency medication as ordered by his / her physician. I also specifically release the school district and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours.</p>	
PARENT / GUARDIAN SIGNATURE: _____	DATE: _____

<p>TO BE COMPLETED BY STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that using my medication in a manner other than prescribed by my doctor can result in disciplinary action taken against me by my school/district.</p>	
STUDENT SIGNATURE: _____	DATE: _____

Please return the fully completed form to your child's school health office signed by the physician, parent/guardian, and student. Medication forms must be renewed at the beginning of each school year or whenever there is a change in medication or instruction.