# Student Health History

**TO BE COMPLETED BY PARENT/GUARDIAN**

Name _____
(Last) (First) (Middle)

Date of Entry _____ Entering Grade _____ Birth date _____ Male/Female

Address _____
(Street) (Town) (Zip Code)

Fathers Name _____ Mothers Name _____

Student's Primary Doctor _____ Phone _____

Last School Attended? _____

| **Does your child** | **Please circle answer** | **Comment as necessary** |
|---|---|---|
| 1. Have allergies (insect/food/environment **CIRCLE**)? | Yes No | To what? _____ |
| 2. Have asthma? | Yes No | How is this treated? _____ |
| History of lung disease? _____ | Yes No | |
| 3. Have frequent sore throats/strep throat? | Yes No | |
| 4. Have frequent stomach aches? | Yes No | Describe _____ |
| 5. Have ear problems/tubes/loss of hearing? | Yes No | Describe _____ |
| 6. Wear glasses or contact lenses? (Please circle) | Yes No | Date of last exam _____ |
| 7. Have an orthopedic/bone/joint problem? | Yes No | Describe _____ |
| 8. Have frequent headaches? | Yes No | Home Treatment _____ |
| 9. Have fainting spells? | Yes No | Describe _____ |
| 10. Have a seizure disorder/staring spells? | Yes No | Comment on reverse side |
| History of concussion? | Yes No | |
| 11. Have diabetes? | Yes No | Comment on reverse side |
| 12. Have a heart condition, chest pain? | Yes No | Describe _____ |
| Family history of sudden death (cardiac/heart) | Yes No | Family member _____ |
| 13. Have kidney or bladder problems? | Yes No | Describe _____ |
| 14. Have anemia or other blood disorder? | Yes No | Describe _____ |
| 15. Have any skin conditions? | Yes No | Describe _____ |
| 16. Have scoliosis? | Yes No | |
| 17. Wear dental braces? | Yes No | |

- What was your child's reaction/ANAPHYLAXIS? _____
- How was this treated? 911, Benadryl, Epi-Pen (please circle)
- Was this doctor diagnosed? Yes No
- Was testing done to confirm the diagnosis Yes No

**PLEASE COMPLETE THE REVERSE SIDE**

## Student Health History

Has your child ever been hospitalized for tests, illness, surgery? Explain if yes _____

_____

Has your child ever been treated for serious injuries or fractures? Explain if yes _____

_____

_____

Does anyone at home have a medical problem? Explain if yes _____

_____

Are there any special problems or conditions we should know about to better understand your child? Explain if yes _____

_____

Does your child take any medication at home? _____

Will it be necessary for your child to take medication in school? Explain _____

_____ (**See nurse for medication regulations)**.

***STUDENTS ENTERING UPK THROUGH 6TH GRADE***
***PLEASE COMPLETE THE FOLLOWING:***

GROWTH AND DEVELOPMENT OF YOUR CHILD

Birth weight _____ Premature birth? Yes No
Age at which your child: Walked _____ Toilet trained _____

***STUDENTS ENTERING 7TH THROUGH 12TH GRADE***
***PLEASE COMPLETE THE FOLLOWING:***

Does your child know how to swim? Yes No

Does your child have any medical restrictions that would prevent full participation in a swim program? Yes No
Explain if yes _____

**IF YOU WISH TO HAVE A CONFERENCE WITH THE SCHOOL NURSE, PLEASE CHECK HERE _____**

Additional Comments:

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