PEORIA UNIFIED SCHOOL DISTRICT

STUDENT HEALTH HISTORY

PLEASE UNDERSTAND THAT BY FILLING OUT THIS INFORMATION IT MAY BE SHARED WITH THE APPROPRIATE SCHOOL AND MEDICAL PERSONNEL.

Student Name: _____ Date of Birth: _____

Last First Middle

The following information may be helpful in assessing a child's health/learning. If you do not wish to complete the entire form, you may wish to speak personally with your school nurse.

DOES YOUR CHILD HAVE OR HAD A HISTORY OF:

- ☐ Allergic to Food _____
- ☐ Allergic to Meds _____
- ☐ Allergies/Seasonal
- ☐ Asthma
  - ☐ Mild ☐ Moderate ☐ Severe
- ☐ Attention Deficit Disorder/ADHD
- ☐ Anxiety
- ☐ Bleeding Disorders**
- ☐ Cerebral Palsy
- ☐ Chicken Pox : Age _____
- ☐ Diabetes**
- ☐ Depression
- ☐ Seizure Disorder/Epilepsy**
- ☐ Scoliosis
- ☐ Other: _____
- ☐ Ear Infections
- ☐ Headaches
- ☐ Migraines (diagnosed by Doctor)
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Kidney Disorder
- ☐ Osgood Schlatter's
- ☐ Irritable Bowel Syndrome
- ☐ Celiac Disease
- ☐ Frequent UTIs (diagnosed by Doctor)

**THESE STUDENTS MUST HAVE A CURRENT TREATMENT PLAN ON FILE IN THE HEALTH OFFICE. **

HAS YOUR CHILD EVER HAD:

- ☐ Surgery
- ☐ Psychological Exam
- ☐ Been in special classes
- ☐ Hearing Problems
- ☐ Tubes in ears
- ☐ Hearing Aids
- ☐ Speech difficulties
- ☐ Serious Accident/injury
- ☐ Vision Problems
- ☐ Is your child restricted from any physical activities (Must have note from Doctor)
- ☐ Or have any food or dietary restrictions

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? LIST ALL BELOW

MEDICATIONS	DOSE	FREQUENCY	REASON

PLEASE EXPLAIN ALL ABOVE MARKED ANSWERS:

THIS INFORMATION WOULD BE HELPFUL TO HAVE IN CASE YOUR CHILD NEEDS TO BE ASSESSED FOR ANY SPECIAL SERVICES:

Prenatal History:
Toxemia: ☐Yes ☐No Diabetes: ☐Yes ☐No
Length of Pregnancy: _____ months Length of Labor: _____ hours Injuries during pregnancy: ☐Yes ☐No

Birth History:
Birth weight: _____ lbs. _____ oz. Needed oxygen? ☐Yes ☐No Jaundice? ☐Yes ☐No Seizures? ☐Yes ☐No

At what age did this child:
Roll over:_____ Sit up:_____ Walk:_____ Dress self: _____ Speak first word: _____
Speak in 2- or 3-word sentences: _____ Daytime bladder control: _____ Nighttime bladder control: _____
Is this child's speech difficult to understand: ☐Yes ☐No

DOES YOUR CHILD HAVE SPECIFIC, SPECIAL MEDICAL/EMOTIONAL NEEDS THAT WE NEED TO BE AWARE OF? IF SO, PLEASE EXPLAIN:

PLEASE CONTACT YOUR SCHOOL'S NURSE TO DISCUSS YOUR CHILD'S MEDICAL CONCERNS.

Signature of Parent/Guardian Date