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

STUDENT HEALTH HISTORY

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.

Has your child ever had any of the following? If "yes", please give age at the time:

Yes___No___Allergies (to what, please list below)
Yes___No___Asthma
Yes___No___Attention Deficit Disorder
Yes___No___Bleeding Disorders
Yes___No___Birth Trauma
Yes___No___Developmental Delays
Yes___No___Epilepsy/Seizures
Yes___No___Other

Yes___No___Ear Infections
Yes___No___Frequent colds
Yes___No___Headaches/Migraines
Yes___No___Heart Disease/Problems
Yes___No___High Blood Pressuure
Yes___No___Kidney Disorders/UTI
Yes___No___Osgood Schlatter's
Yes___No___Scarletina/Strep
Yes___No___Scoliosis/Curvature of Spine

Has your child ever had chickenpox? Yes___No___ If yes, approximate age _____
Is your child diabetic? Yes___No___ If yes-a treatment plan must be on file. Contact your school's nurse.

Has your child ever:

Yes___No___Had Surgery ?
Yes___No___Had a psychological exam ?
Yes___No___Been in special classes ?
Yes___No___Had/have hearing problems ?
Yes___No___Had tubes in his/her ears ?

Yes___No___Had a serious accident or injury ?
Yes___No___Had an accident or injury requiring hospitalization?
Yes___No___Had/have vision problems ?

Does your child have:

Yes___No___Hearing aids ?
Yes___No___Speech difficulties ?

Yes___No___Tubes in ears now ?
Yes___No___Special needs ?

Is your child:

Yes___No___taking medication ?

Yes___No___restricted from physical education ?

If "YES", list medications:
Medication, dosage, frequency Reason for medication

_____
_____

Please explain "YES" answers

_____
_____

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

_____ _____
Parent/Guardian Signature Date

Please contact your school's nurse to discuss your child's medical concerns.