

Health History (Preschool through Sixth Grade)



Student Name _____

Date of Birth _____

Sex: M F

Parent/Guardian Name: _____

Address: _____

Parent/Guardian Telephone: _____

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's safety and educational success. Please contact the school nurse if you have questions. Return the completed form to the school health office.

A. Current Health Status

1. Does your child take medicine or supplements regularly? No Yes

Please list: _____

2. Does your child have a health condition now under treatment? No Yes

Please list: _____

3. Does your child currently have allergies? No Yes

Please list: _____

4. Any concern's about your child's health?

5. Date of last medical exam _____

Dr. _____

6. Date of last dental exam _____

Dr. _____

7. Does your child have current health insurance coverage? No Yes

8. Would you like more information about the state health insurance program? No Yes

B. Check conditions your child has experienced and the date.

Sleeping problem _____

Hives _____

Loss of consciousness _____

Eating problem _____

Chicken Pox _____

Kidney problems/bedwetting _____

Coordination problems _____

Hay Fever _____

Heart problems _____

Tires easily _____

Asthma _____

Diabetes _____

Recurrent headaches _____

Nosebleeds _____

Rheumatic fever _____

Weight problem _____

Blow to the head _____

Pneumonia _____

Eczema _____

Broken bones _____

Convulsions or seizures _____

Behavior/emotional concerns _____

C. Illness and Accidents

Please explain each "yes" answer.

1. Has there been more than one ear infection each year? No Yes

Comments: _____

2. Has there been any hearing problems? No Yes

Comments:

3. Has there been a vision problem? No Yes

If yes, when were they last fitted for glasses? _____

4. Has your child been hospitalized or had surgery? No Yes

If yes, please specify:

D. Previous History

Please explain any "yes" answers.

1. Were there any significant health concerns during pregnancy? No Yes

Comments:

2. Was the pregnancy less than nine months? No Yes

3. Were there medical problems at birth? No Yes

Comments:

4. Birth Weight: _____

5. At what age did your child walk alone? _____

6. At what age did your child say words with meaning? _____

7. Was your child ever enrolled in Early Childhood Special Education or HeadStart? No Yes

Date _____ School attended _____

E. Family History

1. List who lives in the home

2. List any family health problems

Completed by

Relationship to student

Date