HEALTH HISTORY FORM 2022-2023

The following information about your child is requested in order for the School Health Nurse to provide the most appropriate school health services and/or emergency health services for your child.

PLEASE COMPLETE AND RETURN TO THE SCHOOL HEALTH CLINIC

STUDENT'S NAME____ DATE OF BIRTH______________________

GRADE___________________ SEX _______________ (HOMEROOM) TEACHER____

PARENT/GUARDIAN NAME____

HOME PHONE____ WORK PHONE____

PARENTS' CELL PHONE NUMBERS____ ___________________________________

STUDENT'S PHYSICIAN____ PHYSICIAN'S NUMBER______________________________

CHECK ANY THAT <u>CURRENTLY</u> APPLY TO YOUR CHILD	PLEASE DESCRIBE
1. ____ Eye or Vision Problems	1. ________________________________
2. ____ Ear or Hearing Problems	2. ________________________________
3. ____ Lung/Breathing problems, asthma, etc.	3. ________________________________
4. ____ Heart problems/surgery/blood pressure problems	4. ________________________________
5. ____ Kidney/bladder problems, surgery, etc.	5. ________________________________
6. ____ Bone, joint or muscle problems	6. ________________________________
7. ____ Neurological problems, seizures, migraine/headache	7. ________________________________
8. ____ Spine or back problems, surgery, etc.	8. ________________________________
9. ____ History of emotional/mental health problems/treatments	9. ________________________________
10. ____ Alcohol/drug use/abuse or treatment	10. ________________________________
11. ____ Diabetes (type I or type II)	11. ________________________________
12. ____ Cancer (any type)	12. ________________________________
13. ____ ADD/ADHD	13. ________________________________
14. ____ Autism Spectrum Disorder	14. ________________________________
15. ____ Lupus or other autoimmune disorder	15. ________________________________
16. ____ Poor immunity or immune system disorder	16. ________________________________
17. ____ Sickle Cell Disease or blood/bleeding disorder	17. ________________________________
18. ____ Cystic Fibrosis	18. ________________________________

List any chronic or long-term condition:

____

List any surgery; date and reason:

____

List any hospitalization in the last five years:

____

List any restrictions on activity/ physical handicaps:

____

List all daily medications your child takes:

____

____

List ALL of your child's allergies, including to medications, food products and/or insect stings:

____

Please specify those allergies that are severe:

____

Does your child have an Epi-Pen? ________________ **Will you be providing one for the school?** [ ] YES [ ] NO