HEALTH HISTORY

Parents, please provide all health information requested in this double sided form.

Providence Schools

STUDENT'S NAME: *(PLEASE PRINT)* **DATE OF BIRTH**

_____ _____ _____ _____/_____/_____

Last Name *First Name* *Middle initial* *Month* *Day* *Year*

HOME ADDRESS & TELEPHONE NUMBER:

_____ _____ _____ _____

Address *City/Town* *State* *Zip Code*

PARENT/GUARDIAN INFORMATION: *(PLEASE PRINT)*

_____ _____ _____ _____

Name *Home Number* *Work Number* *Mobile Number*

_____ _____ _____ _____

Address *City/Town* *State* *Zip Code*

EMERGENCY CONTACT: *(PLEASE PRINT)*

_____ _____ _____ _____

Name *Home Number* *Work Number* *Mobile Number*

_____ _____ _____ _____

Address *City/Town* *State* *Zip Code*

MEDICAL DOCTOR/CLINIC: *(PLEASE PRINT)*

_____ _____

Name *Telephone*

_____ _____ _____ _____

Address *City/Town* *State* *Zip Code*

MEDICAL HISTORY (Please check one response for each of the following diseases or conditions)

Chickenpox	__Yes	__No	Tuberculosis	__Yes	__No	Headaches	__Yes	__No
German Measles (*Rubella*)	__Yes	__No	Whooping Cough	__Yes	__No	Diabetic	__Yes	__No
Measles	__Yes	__No	Vision Problems	__Yes	__No	Frequent sore throat	__Yes	__No
Mumps	__Yes	__No	Hearing Problems	__Yes	__No	Kidney Problems	__Yes	__No
Pneumonia	__Yes	__No	Asthma	__Yes	__No	Heart Problems	__Yes	__No
Rheumatic Fever	__Yes	__No	Eczema	__Yes	__No	Speech Problems	__Yes	__No
Scarlet Fever	__Yes	__No	Convulsions	__Yes	__No	Other:_____	__Yes	__No

Allergies: ☐Yes ☐No *(please list specific allergies):* _____

_____

Surgeries or Serious Illiness: ☐Yes ☐No _____ *year:*_____

Accidents or Injuries: ☐Yes ☐No _____ *year:* _____

Has the student a lead screening? ☐Yes ☐No If so, please provide the date: _____

Continue form on the back page……..

FOR OFFICIAL USE ONLY

Has the parent been interviewed by a Nurse-Teacher during the initial registration process? Yes☐ No☐

STUDENT'S NAME:			DATE OF BIRTH
_____	_____	_____	_____/_____/_____
Last Name	First Name	Middle initial	Month Day Year

MEDICATIONS

Is the student currently taking any medications? Yes ☐ No ☐ *If yes, please provide the name(s) below*

1._____ ***Dosage:***_____ ***How many times a day?*** __

*Prescribing physician:*_____ *Reason for the medication:*_____

2._____ ***Dosage:***_____ ***How many times a day?*** _____

*Prescribing physician:*_____ *Reason for the medication:*_____

IN THE SPACE BELOW, PLEASE PROVIDE ANY ADDITIONAL *HEALTH INFORMATION*, WHICH YOU FEEL WOULD BE HELPFUL TO THE SCHOOL NURSE-TEACHER.

Who is providing this information? Parent ☐ Guardian ☐ Nurse Teacher, Registration Center ☐

_____

_____

_____

_____

FAMILY HEALTH HISTORY

Allergies _____	Mother ☐	Father ☐	Other:_____
Anemia _____	Mother ☐	Father ☐	Other:_____
Cancer_____	Mother ☐	Father ☐	Other:_____
Convulsive Disorder _____	Mother ☐	Father ☐	Other:_____
Diabetes_____	Mother ☐	Father ☐	Other:_____
Heart Disease _____	Mother ☐	Father ☐	Other:_____
High Blood Pressure _____	Mother ☐	Father ☐	Other:_____
Kidney Disease _____	Mother ☐	Father ☐	Other:_____

What school did your child last attend? _____

_____	_____	_____
City/Town	State	Telephone Number

I UNDERSTAND THIS INFORMATION MAY BE SHARED AND DISCUSSED WITH SCHOOL PERSONNEL IF NECESSARY. I GIVE PERMISSION TO APPROPRIATE SCHOOL PERSONNEL TO COMMUNICATE AND EXCHANGE INFORMATION WITH THE STUDENT'S PHYSICIAN, IF NECESSARY.

_____ _____

Signature Parent/Guardian ***Date***

REVISED 02/12