

# HEALTH HISTORY FORM

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

**STUDENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*Last name, First Name Middle Initial Month Day Year*

**HOME ADDRESS & TELEPHONE: (PLEASE PRINT)**

\_\_\_\_\_  
*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 INFORMATION: (IF DIFFERENT FROM ABOVE)**

\_\_\_\_\_  
*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 off any of the following diseases or conditions the student currently has or has had)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chickenpox                        | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> German Measles ( <i>Rubella</i> ) | <input type="checkbox"/> Whooping Cough   | <input type="checkbox"/> Diabetic              |
| <input type="checkbox"/> Measles                           | <input type="checkbox"/> Vision Problems  | <input type="checkbox"/> Frequent sore throats |
| <input type="checkbox"/> Mumps                             | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Pneumonia                         | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart Problems        |
| <input type="checkbox"/> Rheumatic Fever                   | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Scarlet Fever                     | <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Others                |

Allergies (*please list specific allergies*): \_\_\_\_\_

Surgeries or Serious Illness: \_\_\_\_\_ Year: \_\_\_\_\_

Accidents or Injuries: \_\_\_\_\_ Year: \_\_\_\_\_

Has the student a lead screening? If so, please provide the date: \_\_\_\_\_

**Continues on the next page...**

**OFFICE USE ONLY**

Has the parent been interviewed by a Nurse-Teacher during the initial registration process?

Yes  No

## MEDICAL HISTORY FORM (CONTINUED)

**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

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### FAMILY HEALTH HISTORY

(Please check off any of the following diseases or conditions if it applies)

Allergies _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
Anemia _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
Cancer _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
Convulsive Disorder _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
Diabetes _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
Heart Disease _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
High Blood Pressure _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____
Kidney Disease _____	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Other: _____

What school did your child last attend? \_\_\_\_\_

**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 03/2010