

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

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