

SCHOOL HEALTH SERVICE
HEALTH HISTORY

Dear Parent/Guardian:

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to the Principal or School Nurse.

Child's Name _____ Sex _____ Birth Date _____

1. When was your child's last physical exam? Date _____
Physician/Clinic _____
Purpose of exam: Routine check-up _____ Illness/Injury _____

2. Does your child have a health problem? (Check where appropriate.)
Asthma _____ Diabetes _____ Vision _____ Orthopedic) _____
Injury _____ Hearing _____ Neuromuscular _____ Hay Fever _____
Seizures/Convulsions _____ Heart _____ Mild Allergies _____
Severe Allergies _____ Medication Allergies _____
Other Problems _____
Explain _____

3. Does your child understand his/her condition? Yes _____ No _____

4. Does your child take medication? Yes _____ No _____
Name of medication, dosage and time _____

5. Does the medication affect his/her behavior? Yes _____ No _____

6. Does the medication need to be given at school? Yes _____ No _____

7. Should your child have preferential seating? _____

8. Are there emergency precautions to be taken by school staff? _____

What hospital emergency room do you prefer? _____

Is there anything more about your child's health that you think is important for us to know?
Explain: _____

Parent/Guardian Signature

Date