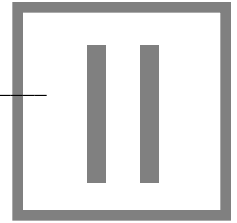


# Health History

# FORM



Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

My child **does** **does not** have health insurance.

Health Insurance Provider: \_\_\_\_\_  
(Optional)

\_\_\_\_\_ Date of last lead test

\_\_\_\_\_ Lead level test result

\_\_\_\_\_ Date of first polio immunization

Please *check box* if your child has a history of any of the following. Please explain in the space provided any item you have circled.

## Explanation

### Accidents/Injuries

Surgeries/Hospitalizations

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### Allergies

Foods  
Drugs  
Animals  
Environment  
Required use of EpiPen or any other medication

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### Respiratory

Asthma/Reactive Airway Disease  
Hayfever  
Croup  
Bronchitis/Pneumonia  
Required use of oral medicine/inhalers/nebulizer

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### Bones/Joint Diseases

Fractures/Dislocations  
Arthritis  
Lyme Disease  
Stitches  
Scoliosis

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### Cardiac

Rheumatic Fever  
Murmurs  
Surgery  
High Cholesterol/High Blood Pressure

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### Chicken-pox Disease or Immunization

If yes, specify which and give date.

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### Dental Appliances

Braces  
Palate Expanders  
Caps

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### Dermatology

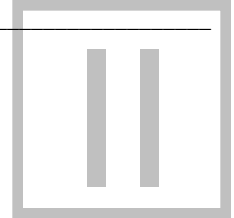
Birthmarks/ scars  
Eczema/Psoriasis

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### Diabetes

Insulin  
Diet

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**Ear/Nose/Throat**

- Ear Infections/ Tubes
- Hearing Loss/Hearing Aids
- Frequent Strep Throat
- Tonsillitis
- Sinusitis

**Gastrointestinal Conditions**

- Frequent Vomiting
- Diarrhea/Constipation
- Eating Problems

**Kidney or Liver Disease**

- Urinary Tract Infections
- Hepatitis Vaccine

**Neurological**

- Concussions
- Headaches/Migraines
- Seizures

**Speech**

- Delayed Speech
- Stuttering or Difficulty With Certain Sounds

**Vision**

- Crossing or Wandering of Eyes
- Color Blindness
- Glasses/Contacts

**Birth History**

- Premature
- Difficulties at birth

**Behaviors Medically Diagnosed**

- Impulsiveness
- Inattention
- Hyperactivity

Does your child take any daily medication including vitamins or herbs?

Does your child have any other physical conditions not covered above?

Is there any other medical information which you feel will help the school nurse and your child's teacher understand your child?

**MEDICAL/PHYSICAL INFORMATION**

Doctor's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

In a medical emergency we hereby authorize the school district to seek emergency medical assistance for our child when we cannot be reached.

Parent/Guardian Name ( <b>Please Print</b> )	Signature	Date
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Parent/Guardian Name ( <b>Please Print</b> )	Signature	Date
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