Health History

FORM II

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

Allergies

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

Respiratory

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

Bones/Joint Diseases

- ☐ Fractures/Dislocations
- ☐ Arthritis
- ☐ Lyme Disease
- ☐ Stitches
- ☐ Scoliosis

Cardiac

- ☐ Rheumatic Fever
- ☐ Murmurs
- ☐ Surgery
- ☐ High Cholesterol/High Blood Pressure

Chicken-pox Disease or Immunization

- ☐ If yes, specify which and give date.

Dental Appliances

- ☐ Braces
- ☐ Palate Expanders
- ☐ Caps

Dermatology

- ☐ Birthmarks/ scars
- ☐ Eczema/Psoriasis

Diabetes

- ☐ Insulin
- ☐ Diet

Explanation

FORM

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 **(Please Print)**	Signature	Date
_____	_____	_____
Parent/Guardian Name **(Please Print)**	Signature	Date