Health History- TWO SIDES

(Must be completed each year)

Student Name: _____ Enrollment Date: _____
Last First Middle

Grade: _____ Female: _____ Male: _____ Date of Birth: _____ Height: _____ Weight: _____
Month/Day/Year

Medication History:
Present medications given daily: _____
Reason: _____
Past medications given regularly: _____
Reason: _____
Additional information: _____

Allergies: Please describe known allergies below. Indicate severity: mild, moderate, or severe:
Drugs _____ Food _____ Bees/Wasps _____ Animals _____ Plants _____ Pollen _____
Dust _____ Smoke _____ Latex _____ Molds _____ Mildew _____ Other _____

Treatment: Please describe allergy treatment this child currently receives, or has received in the past:
Antihistamines _____ Inhalers _____
Desensitizing shots _____ Epipen required _____
Other _____

Injuries, Illnesses and Surgeries: Please list significant history below:

Injuries/Illnesses/Surgeries	Age of Child	Hospitalization Date
1.		
2.		
3.		

Health History: Please check any conditions this child has experienced:

__ Acne
__ Attention Deficit Disorder
__ Anemia
__ Arthritis
__ Asthma
__ Congenital abnormalities _____
__ Cancer: Type: _____
__ Chickenpox: Date: _____
__ Chronic bowel problems _____
__ Cystic Fibrosis
__ Diabetes: Type: _____
__ Depression
__ Dermatitis
__ Eczema
__ Emotional problems: _____
__ Encephalitis: Date: _____
__ Exposed to cigarette smoke regularly
__ Frequent respiratory infections
__ Hay fever
__ Headaches: Type: _____
Treatment: _____
__ Heart Disease: Type: _____
__ Hearing loss: _____
__ Hearing aids: _____
__ Hepatitis: Type & Date: _____
__ Measles: Date: _____
__ Meningitis: Type & Date: _____
__ Multiple ear infections: Last episode: _____
Tubes? _____ Date: _____
__ Mumps: Date: _____
__ Near drowning or suffocation: Date: _____
__ Nervous tic: Type: _____
__ Physical handicap _____
__ Poisoning: Date: _____
__ Pregnancy: Date: _____
__ Rheumatic fever: Date: _____
__ Rubella: Date: _____
__ Seizure disorder: Type: _____
__ Sickle cell disease
__ Substance abuse:
_____ Tobacco _____ Alcohol _____ Drugs
__ Spinal curvature: ___ Scoliosis ___ Kyphosis
__ Suicide risk
__ Urinary tract problems
__ Visual problems
__ Wears glasses or contacts:
Last exam date: _____
__ Other _____
_____
_____

After delivery:
Did the baby experience any of the following? If yes, please describe:
Cyanosis (blue skin color): _____
Jaundice (yellow skin color): _____
Infections: _____
Other: _____

Developmental history: Please indicate the approximate age that this child:
Walked alone _____Spoke in two-word sentences _____
Bowel trained _____ Development compared to siblings or playmates:
Bladder trained _____ ____ Slower ____ Faster ____ Same
Dressed self _____ Other information _____

Sleep Habits or Disturbances:
How many hours does the child sleep each night? _____
Please indicate if the child experiences any difficulties with the following:
___ Mouth breathing ___ Snoring ___ Sleepwalking ___ Bedwetting

Speech Development:
Has the child experienced difficulty with speech? _____ Yes _____ No
If yes, please describe: _____
_____
Has the child received any speech therapy? _____

Dietary Status:
Please describe any concerns with the child's nutrition: _____
_____
Weight concerns _____ Does the child usually eat breakfast? _____
Avoid certain foods? _____ Other food related concerns: _____

Dental History:
Name of Dentist: _____ Date of last exam: _____
Special dental needs or problems: _____

Special Needs:
DO you have other information or concerns about this child's physical or emotional health, growth and development, behavior, or family circumstances that you feel the school should be aware of?
_____
_____
_____

Completed by: _____
Signature
Relationship to child: _____ Date: _____