INITIAL STUDENT HEALTH HISTORY

(Parent/Guardian: The purpose of this form is to work with the School Nurse to identify problems that may affect learning for the student. You may choose not to answer any question or discuss privately with the Nurse.

Student Name:_____ DOB:_____ Today's Date: _____

Person Providing History:_____ Relationship to Student:_____

Is this person the biological parent? Y ☐ N☐

Home Phone:_____ Work Phone:_____ Cell Phone: _____

BIRTH HISTORY- Complete as much as possible

1. Birth Weight:_____ Birth Length:_____ Age in weeks at birth: _____ Premature☐ Full Term☐ Post Term☐
2. Difficult pregnancy (e.g. pre-term contractions, bleeding, illness/infection, eclampsia, pregnancy related diabetes):
   Y☐ N☐ If Y, explain: _____
3. Medications/drugs taken during the pregnancy: None ☐ Over the Counter☐ Prescription☐ Alcohol☐
   Street Drugs☐ Explain reason for medications: _____
4. Did student have problems after birth (e.g. difficulty breathing, yellow skin)? Y☐ N☐
5. Did student receive special care after birth? Y☐ N☐ Explain: _____
6. Length of birth hospital stay:_____ Explain:_____

DEVELOPMENTAL HISTORY

1. Has the student ever received Physical, Occupational, Speech, or Language therapy? Y ☐ N ☐
   If Y, explain:_____
2. Are you or has anyone ever been concerned about the student's growth OR development? Y☐ N☐
   If Y, explain:_____
3. At what age did your child: Walk alone_____ Talk in sentences_____ Complete Toilet training _____

HEALTH HISTORY – ASK THE NURSE IF YOU DO NOT UNDERSTAND ANY OF THE QUESTIONS BELOW

Check any of the following which the student currently has or has had diagnosed in the past.

☐Asthma
☐Allergies
☐Anaphylaxis
☐Anemia
☐ADD/ADHD
☐Thyroid disease
☐Shingles
☐Life changing events/accidents/grief
☐Physical, emotional, or sexual abuse
☐Cancer
☐Depression or other psychiatric diagnosis
☐Diabetes
☐Kidney disease
☐Frequent Urination
☐Nerve or muscle disease
☐ Frequent/severe headaches
☐Convulsion or seizures
☐Excessive thirst
☐Concussion or traumatic brain injury
☐Heart problems or murmur
☐Hepatitis or yellow jaundice
☐Ingestion of poisons/medication
☐Vaccine Preventable Diseases
☐Any Other health concerns or problems

Explain any check mark and give age of problem onset or diagnosis:_____

_____

_____

1. List any other diagnosis, syndrome or disability the student has or has had in past. (List condition, treatment, who diagnosed, etc.) _____

_____

2. Has the student had more than 3 colds, sinus infections, or ear infections in any one year? Y☐ N☐
   If Y, explain:_____