

**STUDENT HEALTH HISTORY**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Interview: \_\_\_\_\_ Individual providing health history: \_\_\_\_\_

**History:**

Were there any issues during pregnancy, labor and/or delivery for this child?  Yes  No

If yes, please describe: \_\_\_\_\_

Does this child have an ongoing health concern? (asthma, diabetes, etc.)  Yes  No

If "yes", please describe: \_\_\_\_\_

Does this child have any allergies?  Yes  No

If "yes", please list: \_\_\_\_\_

Has the allergy required emergency treatment?  Yes  No

If "yes", please explain: \_\_\_\_\_

Are the child's immunizations up to date?  Yes  No

Additional immunizations required: \_\_\_\_\_ given? \_\_\_\_\_

Is there a history of any hospitalizations, significant injuries or surgery?  Yes  No

If "yes", please describe: \_\_\_\_\_

Are there any current medical concerns/injuries?  Yes  No

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Head _____   | <input type="checkbox"/> Eyes _____             | <input type="checkbox"/> Nose _____ |
| <input type="checkbox"/> Ears _____   | <input type="checkbox"/> Throat _____           | <input type="checkbox"/> Neck _____ |
| <input type="checkbox"/> Chest _____  | <input type="checkbox"/> Respiratory _____      |                                     |
| <input type="checkbox"/> Cardiovascular _____                                     | <input type="checkbox"/> Gastrointestinal _____ |                                     |
| <input type="checkbox"/> Genitourinary _____                                      | <input type="checkbox"/> Neurological _____     |                                     |
| <input type="checkbox"/> Musculoskeletal (include any past fractures, etc.) _____ |   |                                     |

Does this child take any medication regularly at home?  Yes  No

Require medication at school?  Yes  No

If "yes", please describe: \_\_\_\_\_

Please list any additional concerns or information: \_\_\_\_\_

Describe child's nutritional pattern and dietary intake: \_\_\_\_\_

List any significant medical concerns in family:

- |   |   |
|---|---|
| <input type="checkbox"/> Mother _____   | <input type="checkbox"/> Father _____       |
| <input type="checkbox"/> Siblings _____ | <input type="checkbox"/> Grandparents _____ |
| <input type="checkbox"/> Other _____    |   |

Who lives with the child in his/her primary household? \_\_\_\_\_

Does child spend a significant amount of time in another household?  Yes  No

If "yes", please describe: \_\_\_\_\_

Who has legal custody of this child? \_\_\_\_\_

Describe any custody arrangements: \_\_\_\_\_

Any additional concerns or pertinent information (use back as needed):

Name and Title of Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_