

NEW STUDENT HEALTH HISTORY

Name: _____ Age: _____ Birthdate: _____

Address: _____ Phone Number: _____

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

Head _____ Eyes _____ Nose _____

Ears _____ Throat _____ Neck _____

Chest _____ Respiratory _____

Cardiovascular _____ Gastrointestinal _____

Genitourinary _____ Neurological _____

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:

Mother _____ Father _____

Siblings _____ Grandparents _____

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):

Parent Signature: _____ Date _____