

**Needham Public Schools
School Health Services
Health History**

Student Name: _____ Age: _____ Birth Date: _____
Entering Grade: _____ School: _____
Parent/Guardian Name: _____
Home Phone Number: _____ Cell Phone Number: _____
Home Address: _____
Email Address: _____

Primary language of family:
English Portuguese Spanish Russian Mandarin Other _____

PURPOSE: The Health History Form is a confidential document required for all students entering the Needham Public Schools. Please inform the school nurses of any changes in your child's health during the school year and contact the school nurse with any concerns or questions.

1. ALLERGIES

Does your child have diagnosed allergies? (check all that applies)

Allergy	Prescribed an EpiPen?	Details about allergy:
Bees/Insects		_____
Foods		_____
Medications		_____
Latex		_____
Cold		_____
Other _____	Details: _____	_____

2. FAMILY HISTORY

Does anyone in your immediate family have a history of asthma, cancer, diabetes, seizures, heart problems, high blood pressure, tuberculosis (TB), color blindness, mental health issues, addiction, or other health conditions? Please describe:

3. GENERAL HEALTH AND DEVELOPMENTAL HISTORY

Does your child have a history of?

	If Yes, please explain
Hospitalizations/surgery	_____
Birth Defect	_____
Fainting episodes	_____
Convulsions/seizures	_____
Frequent headaches	_____

Diagnosed migraines _____
 Frequent nosebleeds _____
 Strep throat _____
 Asthma/wheezing _____
 Cystic Fibrosis _____
 Diabetes _____
 Skin rashes or condition _____
 Heart murmur _____
 Heart condition _____
 Sickle Cell Disease/trait _____
 Painful menstrual periods _____
 Orthopedic problems _____
 Difficulty sleeping _____
 Nightmares _____
 Unusual fears _____
 Aggressive behavior _____
 Tantrums _____
 Self-injurious behavior _____
 Dental problems _____
 Bleeding Disorder _____
 Other condition or syndrome _____ Details: _____

Has your child ever been diagnosed with any of the following?

If Yes, please explain

ADD/ADHD _____
 Autism/Asperger's Syndrome _____
 Developmental delays _____
 Pervasive Developmental Disorder (PDD) _____
 Anxiety _____
 Depression _____
 Eating Disorder _____

4. EYES

Have you observed your child?

If Yes, please explain

Crossing or turning eyes _____
 Squinting _____
 Complaining of double vision/blurry vision _____
 Needing to sit close to the television _____

Has your child had?

Corrective lenses or glasses _____
 Eye surgery _____
 The need to patch an eye _____
 Date of last eye exam _____

5. EARS

Does your child

- Fail to respond appropriately to directions/instructions
- Fail to respond when you call
- Require repetition of questions/instruction
- Wear a hearing aid

If Yes, please explain

Has your child

- Had a hearing test
- Been to a hearing specialist
- Been diagnosed with a hearing loss
- Had frequent ear infections
- Had placement of tubes in his/her ears

Date of last hearing exam _____

BOWEL/BLADDER
Does your child have a history of?

If Yes, please explain

- Frequent stomach aches
- A poor appetite/eating difficulty
- Celiac Disease
- Encopresis
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Urinary tract infections
- Bedwetting
- Incontinence of stool
- Incontinence of urine
- Constipation
- Other _____

Details: _____

INJURIES
Has your child ever had?

If Yes, please explain

- Any serious accident or trauma
- Broken Bones
- A head injury/concussion

8. *Is your child taking any medication, daily or as needed? Please list medications and explain reason for medication.*

9. *Have there been any recent changes in your family that may affect your child, such as: birth of sibling, recent death, family illness, employment, housing, military deployment, or change in marital status?*

10. *Briefly describe your child (for example active, shy, strengths, weaknesses, etc). Please include any information that would be helpful for us to know when caring for your child.*

11. *Do you or your child anticipate any challenges upon entering school?*

12. Is your child covered by health insurance?
Would you like information about State health insurance?

13. When was your child's last dental appointment? _____

14. What other assistance or information may we provide for you or your child?

Signature: _____ Date completed: _____

Name Printed: _____

Relationship to student: _____