**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 yes [ ]  no [ ]  yes [ ]  no [ ]

Foods yes [ ]  no [ ]  yes [ ]  no [ ]

Medications yes [ ]  no [ ]  yes [ ]  no [ ]

Latex yes [ ]  no [ ]  yes [ ]  no [ ]

Cold yes [ ]  no [ ]  yes [ ]  no [ ]

|  |  |
| --- | --- |
| 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?*

 *`*

Yes No 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?*

Yes No 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?*

 Yes No 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*

 Yes No If Yes, please explain

Fail to respond appropriately

to directions/instructions [ ]  [ ]

Fail to respond when you call [ ]  [ ]

Require repetition of questions/

instruction [ ]  [ ]

Wear a hearing aid [ ]  [ ]

*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?*

 Yes No 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?*

 Yes No 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? yes [ ]  no [ ]

 Would you like information about State health insurance? yes [ ]  no [ ]

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:

*Please print and sign this form to bring with you for enrollment*

*\*\*Remember to save this form on your desktop if you would like to have a copy.*