INITIAL STUDENT HEALTH HISTORY

*(Parent/Guardian: The purpose of this form is to identify problems that may affect learning for the student. You may choose not to answer any question. The school nurse is available to help you at #*_____ ☐M ☐T ☐W ☐Th ☐F)

Student Name:_____ DOB:_____ Student #:_____

Person Providing History:_____ Relationship to Student:_____

Is this person the biological parent? **Y** ☐ **N**☐

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

BIRTH HISTORY

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 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 development? **Y**☐ **N**☐
   If **Y**, explain:_____

HEALTH HISTORY

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

☐Asthma	☐Cancer	☐Convulsion or seizures
☐Allergies	☐Depression	☐Excessive thirst
☐Anaphylaxis	☐Diabetes	☐Head injury
☐Anemia	☐Kidney disease	☐Heart problems or murmur
☐ADD/ADHD	☐Frequent Urination	☐Hepatitis (yellow jaundice)
☐Thyroid disease	☐Nerve or muscle disease	☐Ingestion of poisons/medication
☐Shingles	☐Frequent/severe headaches	☐Vaccine Preventable Diseases
☐Life changing events/accidents		☐Other health concerns

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:_____
3. Has the student ever had any vision or hearing problems? **Y**☐ **N**☐
   If **Y**, explain:_____

4. **Medication -** Is the student taking medication now? **Y**☐ **N** ☐
If **Y**, list the medications (include prescribed, over-the-counter, herbal and other remedies) and the condition for which the student takes this remedy): _____

_____

Has the student ever taken any medication for longer than two weeks? **Y**☐ **N**☐
If **Y**, list medication and when it was taken?_____

_____

5. **Sleep** – Number of hours of sleep the student gets most nights: _____ Normal bedtime: _____

Student falls asleep easily. **Y** ☐ **N**☐ Student wakes up easily. **Y**☐ **N**☐
Student wakes up rested. **Y**☐ **N**☐ Student's sleep is: ☐sound ☐restless.

Student: ☐snores ☐ wets his/her pants or wets the bed ☐ has other sleep issues.
Explain:_____

Student has a usual bedtime routine. **Y**☐ **N**☐ Student sleeps in his/her own bed. **Y**☐ **N**☐.

6. **Nutrition** – Student eats at least 3 meals each day. **Y**☐ **N**☐
Student: ☐has healthy appetite ☐is picky eater ☐is sometimes picky ☐ is sometimes not picky.

Do you have any concerns about student's eating? **Y**☐ **N**☐
If **Y**, explain:_____

Do you have any concerns about student's physical activity? Y☐ N☐
If **Y**, explain:_____

Does student have any food allergies? **Y**☐ **N**☐
If Y, explain:_____

7. **Behavior** – Student has friendships that seem normal for his/her age. **Y**☐ **N**☐
If **N**, explain:_____
Do you have any concerns about student's behavior? **Y**☐ **N**☐
If **Y**, explain:_____

8. What schools has student previously attended?_____
9. How many days of school has student missed in the last year? _____ or been tardy?_____

MEDICAL CARE

Primary Care Provider:_____Phone #: _____

Other providers/physicians/specialists:_____

Medical Insurance: Medicaid/Salud MCO:_____
Medicaid #:_____
Other Insurance/Coverage:_____
☐ No Other Insurance/Coverage

Date of last physical exam:_____ Date copy of provider report requested: _____

Summary of Findings:_____

Date of last dental visit/exam:_____ Summary of Findings:_____

School Nurse Name:_____

Nurse Signature:_____ Date:_____