**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.*