

Grade:

STUDENT HEALTH HISTORY

Dear Parent:

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to the school nurse as soon as possible. All information contained in this questionnaire is strictly confidential and will become part of your child's medical record.

Thank you,
ISC School Nurse

Child's Name:

(Last, First, M.I.)

Sex:

☐ M ☐ F

DOB:

(dd/mm/yyyy)

Address:

Phone:

Father's Name:

Mother's Name:

Brothers:

Sisters:

With whom does the child live?

Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Please attach a copy of child's immunization record.

Does your child have a health issue? (Check where appropriate)

☐ Asthma

☐ Diabetes

☐ Vision

☐ Allergies

☐ Hearing

☐ Anemia

☐ Sickle Cell Anemia

☐ Seizures/Convulsions

☐ Heart

☐ ADD/ADHD

☐ Injury

☐ Depression

Explain:

MEDICATIONS

Does your child take medication? ☐ Yes ☐ No

Name of medication(s):

If your child is on PRESCRIPTION medication: *please fill out the release form available at the nurse's office.*

If necessary, would you like the school nurse to administer any of the following medications:

Paracetamol/Aramol/Tylenol ☐ Yes ☐ No

Advil/Ibuprofen ☐ Yes ☐ No

Pepto Bismol ☐ Yes ☐ No

Is there anything more about this child's health that you think is important for me to know?

Parent's/Guardian's Signature

Date