School ____________

SCHOOL HEALTH SERVICE
HEALTH HISTORY

Grade ____________

Dear parent: We would like for 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 health clinic in a sealed envelope. This form will be kept confidential under the guidelines of the Family Educational Rights and Privacy Act (FERPA).

Student's Name____________________ (Last) ____________________ (First) ____________________ (Middle) Sex__________ Birth Date______________

Address____ Phone______________

Father's Name____________________ Mother's Name____________________ Brothers________ (Number) Sister________ (Number) This child is __________ (1st, 2nd, etc.) in family.

1. Does your child have health insurance? ☐ Yes ☐ No Dental Insurance? ☐ Yes ☐ No

2. With whom does your child live?____

3. When did your child last see his/her health care provider? Date:______________ Purpose of exam: Routine Check-up____ Other Reason:______________

4. Please indicate if your child has any of the following health problems (check where appropriate)

Asthma________ Diabetes________ Blood disorder (anemia, sickle cell anemia, etc.)________ Vision problem________ Recurrent strep throat______

Hearing problem________ Seizures________ Heart problems________ Learning problems_______ Recurrent ear infections________ ADHD_______

Behavioral problems_______ Emotional problems________ Developmental problems________ Meningitis or Encephalitis________

Allergies (be s pecific)____

Type of Allergy (What happens? For example, problems breathing, rash)______________ Any Treatment Required?______________________

5. List any medications, vitamins or herbal supplements your child takes:______________________________

6. Does your child require any special services (ex. breathing treatments, tube feedings, etc.)? Explain:______________________

7. Has your child been hospitalized since birth?_____ Explain:______________________________

8. Has your child ever had any surgeries?______ Explain:______________________________

9. Please indicate if any close relative in your family has a history of any health problem. Please indicate the relationship to the child (For Example: M - Mother, F - Father, GM - Grand mother, GF - Grandfather, B - Brother, S - Sister, C - Cousin, U - Uncle, A - Aunt).

Asthma________ Diabetes________ Blood disorder (anemia, sickle cell anemia, etc.)________ Cancer________ High blood pressure______

Hearing problems________ Seizures________ Heart disease________ Learning problems_______ ADHD_______ High cholesterol_______

Emotional problems________ Birth defect________ Mental retardation________ Tuberculosis________

10. Are there any problems in the home which might affect your child's learning?______ Explain______________________________

11. If your child has a medical problem, we may need to contact his/her health care provider for information, treatment orders, etc. Check here if you give permission for the school health assistant, nurse or nurse practitioner to contact your child's health care provider if needed. ☐ Yes ☐ No If you indicated "Yes," please list your child's health care provider and phone number:

____ Phone Number______________________

12. Is there anything more about your child's health that you think is important for us to know?______________________________
(Please explain on separate sheet and attach to this form)

Signature:______________________________ Relationship to child:______________ Date:______________

Tazewell Co. Public School District is certified to provide EPSDT (Early Periodic Screening Diagnosis and Treatment) screening.