HEALTH HISTORY UPDATE

Date: _____ School: _____

Student: _____ Birthdate: _____ Age: _____ Grade: _____

Address: _____ Home Phone: _____

City, State, Zip Code: _____

Mother's/Guardian's Name: _____ Cell Phone: _____

Father's/Guardian's Name: _____ Cell Phone: _____

Parent/Guardian signature: _____ Relationship to student: _____

In the last 3 years, has your student had concerns with any of the following?

Respiratory (Asthma, Bronchitis, etc.): Yes /No	Heart: Yes / No	Immune: Yes / No
Severe Allergies: Yes / No	Blood: Yes / No	Hearing: Yes / No
Diabetes: Yes / No	Orthopedic: Yes / No	Vision: Yes / No
Head Injury: Yes / No	Skin: Yes / No	Growth/Nutritional: Yes / No
Seizures/Neurological: Yes / No	Bladder/Kidney: Yes / No	Developmental: Yes / No
Headaches / Dizziness / Fainting: Yes / No	Stomach/Intestines: Yes / No	Other Health: Yes / No

Emotional/Behavior/Social (sad, mad, worried, hyperactivity, sensory, repetitive behaviors, etc.) Yes / No

If yes to any of the above, please explain in detail: _____

_____

Have any changes in home life or other events occurred in the last 1-3 years that may affect your student's health or ability to concentrate in the classroom? (family illness, death, birth, moves, etc.)?_____

_____

Current Diagnoses:

1. Diagnosis: _____

   Doctor/Healthcare Provider: _____ Specialty: _____

   Frequency/Duration of appointments: _____

   Date of first appointment: _____ Discharge Date: _____ Continues to see: _____

2. Diagnosis: _____

   Doctor/Healthcare Provider: _____ Specialty: _____

   Frequency/Duration of appointments: _____

Date of first appointment: _____ Discharge Date: _____ Continues to see: _____

Current Medications:

1. Medication: _____ Dose: _____ Frequency:_____ Taken at: Home / School

   Diagnosis: _____ Start date: _____ Doctor: _____

2. Medication: _____ Dose: _____ Frequency:_____ Taken at: Home / School

   Diagnosis: _____ Start date: _____ Doctor: _____

Hospitalizations in the last 3 years:

Hospital: _____ Admission and Discharge Dates: _____

Diagnosis: _____ Doctor: _____

Additional Information:

_____

_____

Illnesses, Accidents, and/or Injuries in the last 3 years: _____

_____

_____

General Wellness:

Extracurricular activities: (friends, sports, reading, TV, video games, hiking, cooking, etc…)_____

_____

Exercise: _____

Sleep Habits: _____

Eating Habits: _____

Dental Health: _____

_____

Other: _____

_____

Do you believe the medical history has any impact on you son/daughter's educational performance? Yes / No

Please return this completed document to the School Nurse.