



HEALTH HISTORY UPDATE

INSPIRE. EMPOWER. NURTURE.

Enter with promise. Leave with purpose.

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.