Saint Paul Public Schools
A World of Opportunities

Health Information and History

The information you provide may be shared by the school nurse with school staff who need to plan for your student's education and/or to ensure your student's health and safety.

General Information:

Child's Name: _____ DOB: _____ Sex: Male Female

Completed by: _____ Date: _____
(relationship/title)

Health Care:

Health Care Provider (HCP)/Clinic: _____

Dentist/Clinic: _____

Do you have health care coverage? ☐ Yes ☐ No ☐ Applied ☐ Not Interested

Date of child's last well child health exam: _____

Date of child's last dental checkup: _____

Family History

(Check all ☒ that apply for parents, grandparents, brothers, sisters, etc.)

		Who:			Who:
☐	ADD/ADHD		☐	High Blood Pressure	
☐	Allergy		☐	Learning Problems	
☐	Asthma		☐	Mental Health Issues	
☐	Deafness		☐	Other Blood Disorders	
☐	Diabetes		☐	Reading Problems	
☐	Epilepsy or Seizures		☐	Sickle Cell Anemia/Trait	
☐	Growth Problems		☐	Tuberculosis	
☐	Heart Problems				

Are there any other serious health problems with any family member? _____

_____

Pregnancy and Birth

*(Check all ☑ that apply to child and **explain**)*

☐ Adopted. If Yes, at what age: _____

☐ Problems during the pregnancy or delivery: _____

☐ Prescription medications, alcohol, cigarettes, or street drugs used during pregnancy: _____

_____

☐ Born more than 3 weeks early or late. Child's birth weight _____ lbs. _____ oz.

☐ Problems at birth: _____

☐ Hospitalized for medical reasons after birth: _____

_____

Growth and Development

☐ Learned to do things at the same age as other children *(sit, stand, walk, talk, become toilet trained, etc.)*

If **Not**, please explain: _____

_____

_____

Childhood Illnesses

*(Check all ☑ that apply to child and **explain**)*

Has had the following diseases:

☐ Chicken Pox (Varicella)
☐ Frequent Strep Infections
☐ Pertussis (Whooping Cough)
☐ Has been exposed to TB (Tuberculosis)
☐ Meningitis
☐ Pneumonia

☐ Other serious illnesses: _____

☐ Overnight hospitalizations because of an accident, injury, or illness: _____

☐ Emergency Room visits: _____

☐ Surgery: _____

☐ Seen a medical specialist: _____

Safety/Injuries

*(Check all ☑ that apply to child and **explain**)*

☐ Had a serious injury: _____

☐ Had an accidental poisoning: _____

☐ Had lead poisoning: _____

Present Health

*(Check all ☑ that apply to child and **explain**)*

Has ever been told by a doctor as having:

☐ ADD/ADHD ☐ Asthma ☐ Diabetes ☐ Seizures

☐ Other *(please explain)*: _____

_____

☐ **Takes medication.** Please list: _____

_____

Activities of daily living/needs assistance with:

☐ Toileting ☐ Activity/Mobility ☐ Dressing ☐ Nutrition/Eating

Explain: _____

_____

Allergies

*(Check all ☑ that apply to child and **explain**)*

Has had the following problems:

☐ Medication allergy: _____

☐ Hay Fever: _____

☐ Severe reaction to insect stings *(breathing problems/hives)*: _____

☐ Food allergy: _____

☐ Food intolerance: _____

☐ Has EpiPen: _____

☐ Other allergies: _____

_____

Skin

*(Check all ☑ that apply to child and **explain**)*

☐ Problems with rashes: _____

☐ Eczema: _____

☐ Unexplained lumps or spots: _____

☐ Bruises easily: _____

Head/Neurological

*(Check all ☑ that apply to child and **explain**)*

☐ Had one or more head injuries: _____

☐ Had a period of unconsciousness as a result of a head injury: _____

☐ Has frequent/severe headaches: _____

☐ Has some unexplained movement or jerks: _____

☐ Has seizures: _____

☐ Has a weakness in his/her body: _____

☐ Has staring spells: _____

☐ Is clumsy and awkward: _____

Eyes/Vision

*(Check all ☑ that apply to child and **explain**)*

☐ Has a vision problem: _____

☐ Wears glasses or contact lenses: _____

Ear, Nose, and Throat

*(Check all ☑ that apply to child and **explain**)*

☐ Has ear problems: _____

☐ Seems to have trouble hearing: _____

☐ Has PE tubes in his/her ears: _____

☐ Has frequent nosebleeds: _____

☐ Has swollen glands frequently: _____

Dental

*(Check all ☑ that apply to child and **explain**)*

☐ Has trouble with teeth, gums, or mouth: _____

☐ Had teeth chipped or damaged: _____

Respiratory

*(Check all ☑ that apply to child and **explain**)*

☐ Had episode(s) of wheezing *(whistling in the chest)* in the last 12 months: _____

☐ Heard wheeze or cough after active playing in the last 12 months: _____

☐ Had attack of coughing during sleep during the last 12 months: _____

☐ Other breathing problems *(pleas describe)*: _____

Cardiovascular *(Check all ☑ that apply to child and **explain**)*

☐ Has a heart murmur: _____

☐ Has a heart condition: _____

☐ Seems to tire easily: _____

Stomach/Gastrointestinal *(Check all ☑ that apply to child and **explain**)*

☐ Vomits frequently:

☐ Has frequent stomach aches: _____

☐ Has frequent diarrhea: _____

☐ Has constipation: _____

☐ Has bloody stools: _____

☐ Soils his/her underwear: _____

☐ Has a stomach problem: _____

Urinary *(Check all ☑ that apply to child and **explain**)*

☐ Has kidney or bladder problems: _____

☐ Complains of pain when urinating: _____

☐ Urinates frequently: _____

☐ Has daytime or nighttime accidents: _____

Bones and Muscles *(Check all ☑ that apply to child and **explain**)*

☐ Problem with bones or muscles: _____

☐ Pain in joints or bones: _____

☐ Limps: _____

☐ Wears corrective shoes, brace, or shoe inserts: _____

Behavior/School/Social *(Check all ☑ that apply to child and **explain**)*

Shows the following behaviors:

☐ Acts without thinking	☐ Gets good school/childcare reports	☐ Is irritable, easily upset
☐ Angers easily	☐ Gets overly excited	☐ Is overly active
☐ Breaks things	☐ Has nervous habits	☐ Is usually content or happy
☐ Follows directions	☐ Is fearful or shy	☐ Plays well/socializes with others

☐ I have concerns about some of child's behaviors: _____

☐ History of depression or mental health issues: _____

Adolescent History *(Check all ☑ that apply to child and **explain**)*

☐ Pregnant: _____

☐ Married: _____

☐ Parenting: _____

☐ Menstrual difficulties: _____

☐ Concerns about weight: _____

☐ Concerns about chemical use: _____