MILLBROOK CENTRAL SCHOOL DISTRICT HEALTH HISTORY

Student name:_____ **Sex:**_____ **Date of birth:**_____
(Last, First, MI)
Parent/Guardian: _____**Relationship to child:**_____

Parent/Guardian: _____**Relationship to child:**_____

Siblings:_____ **Date of Birth**:_____ _____**Date of Birth:**_____

_____**Date of Birth**:_____ _____**Date of Birth:**_____

Check YES or NO to all items. Provide details on right for any items marked YES.

YES	NO	ALLERGIES	Details / Dates *List specific allergy and type of reaction
☐	☐	Food allergy	
☐	☐	Peanut allergy	
☐	☐	Tree nut allergy	
☐	☐	Medication allergy	
☐	☐	Seasonal or environmental allergies	
☐	☐	Allergy to bees, other stinging insects	
☐	☐	History of sting allergy in family (specify)	
☐	☐	Has child ever been stung ?	
☐	☐	Does child have an Epi-Pen ?	
☐	☐	Other allergies:	
YES	**NO**	**Health Conditions**	**Details / Dates**
☐	☐	Asthma / Reactive airway	
☐	☐	Does child use an inhaler and/or nebulizer?	
☐	☐	Pneumonia or lung disorder	
☐	☐	Heart murmur	
☐	☐	Heart condition / high blood pressure	
☐	☐	Bleeding disorder / Anemia	
☐	☐	Diabetes Date diagnosed: Insulin dependent: Yes ☐ No☐	
☐	☐	Diabetes in immediate family?	
☐	☐	Seizure disorder Type: Medication:	
☐	☐	Serious concussion or head injury	
☐	☐	Recurrent headaches /migraines	
☐	☐	Serious accident / injury	
☐	☐	Surgery / Hospitalizations:	
☐	☐	Fractures : specify	
☐	☐	Joint or muscle disease / orthopedic problems	
☐	☐	Scoliosis or abnormal spinal curve	
☐	☐	Kidney or urinary problems	
☐	☐	Bowel or digestive problem	
☐	☐	Lactose intolerance	
☐	☐	Gluten intolerance (celiac disease)	
☐	☐	Skin condition	
☐	☐	Lyme disease	
☐	☐	Rheumatic fever	

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Check YES or NO to all items. Provide details on right for any items marked YES.

YES	NO	Health Conditions	Details / Dates
☐	☐	Mononucleosis (Mono)	
☐	☐	Chicken pox (varicella)	
☐	☐	Attention Deficit Disorder (ADD or ADHD) Date diagnosed: Current medication: Previous medication:	
☐	☐	Autism / Asperger's	
☐	☐	Neurological disorder	
☐	☐	Behavioral or psychological disorder	
☐	☐	Other:	

YES	NO	Specialists / Services	Details / Dates
☐	☐	Speech/Language	
☐	☐	Occupational Therapy	
☐	☐	Physical Therapy	
☐	☐	Neurologist	
☐	☐	Psychology services	
☐	☐	Allergist	
☐	☐	Ear, Nose and Throat Specialist / Audiologist	
☐	☐	Ophthalmologist / Optometrist	

YES	NO	Hearing and Vision	Details / Dates
☐	☐	Frequent ear infections / fluid in ear	
☐	☐	Hearing loss: Left ☐ Right ☐ Due to: Last evaluation:	
☐	☐	Hearing aid	
☐	☐	Vision problems/ eye defect Date of last vision exam:	
☐	☐	Wears glasses ☐ Contacts ☐ Both ☐ At all times: ☐ Distance: ☐ Reading: ☐	
☐	☐	Color deficiency	
☐	☐	Other:	

List all medications your child takes on a daily or frequent basis:_____

_____

***Are there any medications to be taken while school is in session?**_____

**School medication policy, including physicians order, must be followed.*

List any health concerns not previously addressed:_____

_____

Parent/Guardian Signature_____**Date:**_____

(4/25/08)