Hillsboro Independent School District Student Health Services

STUDENT ENROLLMENT HEALTH HISTORY

Student's Full Name_____ Date of Birth_____ Gender_____ Grade_____

Name of Parent(s) or Guardian(s):_____

This information will be utilized by the school nurse to develop a health plan for your child if necessary. Information regarding your child's health condition will be shared only with staff who need to know to assist your child in school.

Who is your child's primary doctor?_____ City_____ Phone_____
Does your child see a specialist for any reason? □Yes □No
If yes, for what reason is your child being seen?_____
Specialist's name _____ City_____ Phone _____

Does your child have:

ADD/ADHD	□Yes	□No	Specify_____
Tourette Syndrome	□Yes	□No	Specify_____
Bipolar	□Yes	□No	Specify_____
Other psychological condition	□Yes	□No	Specify_____
Epilepsy or seizures	□Yes	□No	Specify_____
Other neurological condition	□Yes	□No	Specify_____
Allergies to	□Yes	□No	Specify_____
food, medicine, insects,			Type of reaction_____
or environmental triggers			Emergency medication_____
Asthma	□Yes	□No	Specify_____
Diabetes	□Yes	□No	Insulin □Yes □No
Frequent ear infections	□Yes	□No	Specify_____
Headaches/migraines	□Yes	□No	Specify_____
Heart condition	□Yes	□No	Specify_____
Orthopedic (bone/joint) or musculoskeletal condition	□Yes	□No	Specify_____
Kidney or bladder condition	□Yes	□No	Specify_____
Bowel problems (ex. constipation, diarrhea)	□Yes	□No	Specify_____
Gastric reflux/heartburn	□Yes	□No	Specify_____
Skin condition (ex. eczema, psoriasis)	□Yes	□No	Specify_____
A birthmark	□Yes	□No	Specify_____
History of surgery	□Yes	□No	Specify_____
Hearing or vision problem	□Yes	□No	Specify_____
			□Hearing device Specify_____
			□Glasses □Contacts
Other condition not specified	□Yes	□No	Specify_____

Does your child:

Take daily medication	□Yes	□No	Specify_____
Take emergency medication	□Yes	□No	Specify_____

Additional information regarding medical conditions/surgeries:_____ _____
_____

Please notify the school as soon as possible to inform us of any changes to this information. If your child has a medical condition that needs an individual health plan formulated, you will be contacted.

My signature indicates that the above information is complete and true to the best of my knowledge.

Parent or Guardian Signature_____ Date_____