STILLWATER TOWNSHIP SCHOOL

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HEALTH HISTORY FORM 2020/2021

Name of Child:_____ Grade/Teacher:_____

Please check all that apply with the month and year:

Asthma _____	Chicken Pox_____	Strep Infection_____
Mononucleosis_____	Headaches _____	Anemia_____
Pneumonia _____	Bed Wetting_____	Eye Problems _____
Hearing Problems _____	Rheumatic Fever_____	Hepatitis _____
Neuromusc. Dis._____	Heart Disease _____	High Fevers _____
Skin Problems_____	Dental Problems _____	Speech Problems _____
Congenital. Defects_____	Convulsive Dis. _____	Diabetes Type I/Type II_____
Stomach Problems _____	Bowel Problems_____	Urinary Problems _____
Unconsciousness _____	Lymes Disease _____	Murmur_____

Other: _____

Operation or injuries: _____

If yes, please describe: _____

Allergies:

Medication: YES/NO (circle one) If yes, pease list: _____

Reaction: _____

Does your child use an Epi-Pen? YES/NO (circle one) If yes, please contact school nurse for more information

Food: Yes/No (circle one) If yes, pease list:_____

Reaction: _____

Does your child use an Epi-Pen? Yes/No (circle one) If yes, please contact school nurse for more information

Current Health Status:

Is your child being treated by a healthcare provider for any current condition? YES/NO (circle one)

If so, please explain:_____

Is your child currently taking any medication; YES/NO

If yes, please indicate name of medication : _____

Any other pertinent health information you feel the school nurse should be aware of?

OVER

RESPONSES TO THE FOLLOWING ITEMS ARE OPTIONAL:

Pregnancy and Birth

Was this pregnancy unusual in any way? Yes [ ] No [ ]
Were there any complications during the birth of this child? Yes [ ] No [ ]
If yes, explain: _____
_____

Early Childhood:

Were there any problems with feeding or sleep patterns? Yes [ ] No [ ]
If yes, explain: _____
_____

At what age did your child:
Sit:_____ Stand: _____ Walk: _____ Feed self: _____

Toilet Train: _____ Speak words: _____ Speak in sentences: _____

Family Health History *(Circle any that apply)*

Has any relative had : Allergies, Asthma, Drug or Alcohol Addiction, Rheumatic Fever, Heart Disease, Diabetes, Tuberculosis, Convulsive Disorders, Mental Illness or Cancer?

Signature of Parent/Guardian:_____ **Date**:_____