REMSEN ELEMENTARY STUDENT HEALTH HISTORY

(Please complete FRONT and BACK)

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:
Family Physician:	Phone #:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury or illness requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a **concussion** or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Severe uncorrectable loss of vision in one or both eyes?	☐	☐	
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	
Sudden death of family member	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Chicken Pox
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Epilepsy/Seizures
- ☐ Fractures
- ☐ Frequent Colds
- ☐ German Measles
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (Depression, eating disorder, Anxiety, OCD, ODD, etc.)
- ☐ Measles or Mumps
- ☐ Nephritis
- ☐ Operations
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Serious Injury
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Sore Throat
- ☐ Speech Condition
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Urinary Condition
  - ☐ Other:

If YES to any of the following, please describe: ______

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CURRENT MEDICATIONS	YES	NO	Please list medication name, dose, time(s) & reason for taking

Given at school (**IF YES** – Medication administration form **MUST** be provided by child's health care provider)	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any other special condition(s) about your child's health that the school health office should know?

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Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes: ____

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Date of last physical: ______________________

Since your child's last physical examination has your child had any injury or medical illness? If yes, please explain: _______

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Date of last Hearing Test:______________________

Date of last Vision Test: ______________________

Date of last Dental Exam:______________________

Parent/Guardian Signature:______________________________________Date:__________________