WESTBOROUGH PUBLIC SCHOOLS

STUDENT HEALTH HISTORY (Pre K – Grade 3)

Vision screenings are done in grades PreK, and 1-3. Hearing screenings are done in grades K-3. Height and weight screenings are done in grade 1. Please notify the school nurse if you do not want your child to participate in any of these mandated screenings.

Student's Name ____ Date of Birth ________________

Address ____Home Phone __________________

Parent/Guardian ______________________
Can dismiss student: ☐Y ☐ N
Employer_______________________
Work Phone_______________________
Cell Phone_______________________

Parent/Guardian _________________________________
Can dismiss student: ☐Y ☐ N
Employer _________________________________
Work Phone _______________________________
Cell Phone_________________________________

Child lives with ____________________________ Language spoken at home________________________

Siblings/ages ____

EMERGENCY CONTACTS (Local adults who will care for your child if you cannot be reached)

Name ___________________________Relationship________________Phone________________________

Name ___________________________Relationship_______________ Phone________________________

HEALTH CARE PROVIDERS

Doctor/NP/PA ____ Phone______________________

Dentist ____ Phone______________________

Health insurance Company ______________________________________ Policy # ____________________

If you do not have health insurance, please contact the school nurse for information about Massachusetts programs.

Is there a family history of chronic illness, mental health issues, learning disabilities, health issues, etc?
☐ No ☐ Yes
If yes, please explain: ____

CHILD HEALTH HISTORY

Were there any significant problems during pregnancy? ☐ No ☐ Yes
If yes, please explain: ____
Length of pregnancy: _________ weeks Birth weight: ______ lbs. ______ oz.
Were there any complications that occurred during or after birth? ☐ No ☐ Yes
If yes, please explain: ____
Is there any other information you'd like to share about this child's birth history? (i.e. adoption)

____

At what age did your child do the following: Sit __________ Crawl __________ Walk __________
Say their first word __________ Say their first sentence __________
Become toilet trained: Day __________ Night _________

MEDICAL/MENTAL HEALTH CONCERNS: (such as asthma, diabetes, heart conditions, seizures, migraines, anxiety, depression, ADHD, behavioral concerns, etc. Please attach additional pages if necessary):
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____

Has your child ever had any significant injuries, illness, or hospitalizations? ☐ No ☐ Yes
If yes, please explain: ____
Does your child have any allergies? ☐ No ☐ Yes
If yes, please explain: ____
Does your child have an EpiPen for severe allergies? ☐ No ☐ Yes
Is your child on a special diet related to allergies, intolerances, or a health concern? ☐ No ☐ Yes
If yes, please explain: ____

Has your child been evaluated for vision problems? ☐ No ☐ Yes
If yes, please explain: ____
Does your child wear glasses? ☐ No ☐ Yes

Has your child had frequent ear infections? ☐ No ☐ Yes
If yes, please explain: ____

Has your child ever been evaluated for hearing problems? ☐ No ☐ Yes
If yes, please explain: ____

Is your child presently taking any medications? ☐ No ☐ Yes - please indicate:

Name of Medication ____________________ Dose _________________ Time given _________

Name of Medication ____________________ Dose _________________ Time given _________

Name of Medication ____________________ Dose _________________ Time given _________

If your child requires medicine or any special treatment while at school, please contact the school nurse. A signed order from a licensed prescriber and parental permission is required for treatment or medicines given at school (except as noted below).

Is this child presently under care of a physician, other than for regular check-ups? ☐ No ☐ Yes
If yes, please explain: ____
Are there any restrictions on this child's activities? ☐ No ☐ Yes
If yes, please explain: ____
Is there anything else about this child's health that you would like to share?

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PARENTAL CONSENT for OVER-THE-COUNTER MEDICATIONS (during school hours)

I give permission for the school nurse to provide and administer the following over-the-counter medications to my child, as needed, based on nursing assessment:

Acetaminophen (Tylenol): For mild to moderate discomfort of muscles, menstrual cramps, toothache, headache, mild fever. (Note: Any student with a temperature greater than 100°F must be dismissed to a parent or emergency contact). Maximum dose: 650mg.

❒ Yes ❒ No

Ibuprofen (Advil, Motrin, Nuprin): For mild to moderate discomfort of muscles, menstrual cramps, toothache, headache, mild fever. (Note: Any student with a temperature greater than 100.0°F must be dismissed to a parent or emergency contact). Maximum dose: 400mg.

❒ Yes ❒ No

Tums (Calcium carbonate): For indigestion, stomach upset. Maximum dose: 1-2 pills regular strength.

❒ Yes ❒ No

Throat lozenges: For sore throat, cough. Maximum dose: 1-2 per day.

❒ Yes ❒ No

Parent/Guardian Signature ____ Date____________

· I give permission for the nurse to provide minor first aid treatment which may include the application of antibiotic ointment or skin care products such as a mild cleanser, hand lotion, or lotion with Caladryl, aloe, or lidocaine.

· I give permission for the nurse to share relevant information with appropriate school personnel to meet the health and safety needs of my child.

· In case of an accident or serious illness, I request that the school nurse contact me. If unable to reach me or one of my designees, I authorize the school to contact my child's medical provider. If needed, the school will call 911 and send my child with an adult from school to the hospital for emergency treatment. The school has no liability for medical costs.

Parent/Guardian Signature ____ Date ____________