MIDLAND BOROUGH SCHOOL DISTRICT HEALTH SERVICES
Student Health History

Child's Name ______________________________ Sex: M F DOB ______________

Please circle your response when choices are provided.

A. Medical History (check those that apply to your child and supply dates):

CONDITION	√	DATE (S)	CONDITION	√	DATE (S)	CONDITION	√	DATE (S)
ADD/ADHD			Fibromyalgia			Scarlet Fever		
Arthritis			Gastrointestinal			Scoliosis		
Asthma			Hernia			Seizure Disorder		
Bronchitis			Hemophilia/Bleeding			Sickle Cell Disease		
Cerebral Palsy			Headaches			Speech Problems		
Chicken Pox Disease			Heart Disease			Spina Bifida		
Coordination Issues			Menstrual Problems			Tonsilitis		
Cystic Fibrosis			Migraines			Tuberculosis		
Diabetes			Pneumonia			Urinary Problems		
Eating Disorder			Psychological Issues			Whooping Cough		
Enuresis-Bedwetting			Rheumatic Fever			Other – list below		

Other: ______________________________

B. Allergies: Plants _____ Bees and insects _____ Animals _____ Food(list) ______________
Drugs(list) ______________ Other ______________

Is Epi-Pen Needed? Yes No Is Benadryl Needed? Yes No

Students with known severe allergies requiring medication must provide a doctor's order and the medication.

C. Is **medication** needed for any other condition:
At home? If "yes", list condition and medication ______________

____

At school? If "yes", list condition and medication ______________

____

D. List any **operations, injuries, or hospitalizations**. Give dates: ______________

____

____

E. Is **physical activity** limited ? Yes No (A physician note is needed to be excused from physical education classes.)

If activity is to be limited, please explain:______________________________

F. Is your child presently **under medical treatment**? Yes No If so, name of physician:______________

Reason for treatment:______________________________

G. List any **physical handicap** about which the teachers should know:______________

____

H. List any **psychological issues** that may impact education: ______________

____

I. Vision and Hearing:

Does your child wear glasses? Yes ______ No ______ Does your child wear contact lenses? Yes _____ No _____

Does your child have any of the following?

EYES			*EARS*		
Squinting	Yes ______	No ______	Difficulty Hearing	Yes ______	No ______
Cross Eyes	Yes ______	No ______	Frequent Ear Infections	Yes ______	No ______
Difficulty Seeing	Yes ______	No ______	Draining Ears	Yes ______	No ______

THE FOLLOWING INFORMATION IS NEEDED FOR AGE 4 AND AGE 5 KINDERGARTEN ONLY

Does your child dress him/herself? Completely Partially Not at all

Is your child toilet trained? Completely Partially Not at all

Are there any problems with toilet habits?____

Which hand does your child use the most? Left Right Uses different hands for different activities

Does your child have any speech problems or stuttering? Yes No Explain ______________________________

Does your child have any feeding problems? Yes No Explain ______________________________

Is your child (circle all that apply:

Angry Bashful Fearful Friendly Happy Nervous Sad Selfish Short-tempered Stubborn

Circle any concerns:

Thumbsucking Daydreams Nightmares Temper-Tantrums Lying Destructive Clinging Sensitive

Did your child attend Head Start, Nursery School or another Kindergarten? If yes, list other schools and dates. ____________
____

Do you need an appointment with the school nurse to review this information? Yes No

Do you permit information to be shared with school staff on a "need to know" basis? Yes No

____ ______________________

Signature of Parent/Guardian *Date*

_____ Reviewed by School Personnel ______________________________ ______________________

Check *Signature* *Date*