Sandusky City Schools
HEALTH HISTORY FORM
Kindergarten through Fifth Grade

Grade____

To be completed by parent or guardian.
Please print or type

Student's Name_____ _____ Birth Date_____ Sex M F
Last First Middle

With whom does this child live? _____ _____
Name Relationship

Who in this child's legal guardian? _____ _____
Name Relationship

PERINATAL HISTORY

Was this infant born: full term____ early____ late____ What was the infant's birth weight? ____lbs.____oz.

Did the infant have any sickness or problems while in the nursery? Yes____ No____

If Yes, explain briefly_____

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:

walked alone_____ was toilet trained_____ spoke in sentences_____ dressed self_____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?

____About the same ____Slower ____Faster

HEALTH CONDITIONS

Please check all that this child has had:

____Abnormal spinal curvature (Scoliosis, etc)
____Allergies
____Anemia
____Asthma
____Attention Deficit Disorder
____Bedwetting at night
____Wetting during the day
____Urinary tract infection
____Behavior problem
____Birth defect
____Cancer, Type_____
____Chicken Pox
____Chronic diarrhea
____Chronic constipation
____Stool soiling
____Concern about relationship with siblings or friends
____Cystic Fibrosis
____Dental problems
____Diabetes
____Eczema
____Emotional problems
____Eye problems
____Frequent headaches
____Frequent skin infections
____Hearing problems
____Heart disease, type_____
____Hepatitis
____Kidney disease, type_____
____Meningitis
____Multiple ear infections (3 or more per year)
____Near-drowning or near-suffocation
____Nervous twitches or tics
____Poisoning
____Pregnancy
____Rheumatic Fever
____Seizures or epilepsy
____Sickle Cell disease
____Substance abuse (alcohol, drugs)
____Suicide attempt
____Other _____

Please complete information on *both* sides of this form.

INJURIES, ILLNESSES, AND SURGERIES

Please list any severe injuries, illnesses, and surgeries:

Injuries, Illnesses, Surgeries	*Age of Child*	*Date(s) of Hospitalization*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list and describe allergies or reactions to:

Medicines/drugs_____

Foods/plants/animals/other_____

Bee Stings_____

Recommended treatment if allergy is severe_____

ADDITIONAL INFORMATION:

What medications are given daily?_____

What medications are given frequently, but not daily?_____

This child is usually: ____very active ____normally active ____rather inactive

Do you have any concern about how your child gets along with other children?_____

_____

_____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly:_____

_____

_____

_____

==========

Parent/Guardian Consent

My child will have a physical examination by the family physician, MD, DO, or CNP.

By signing this, I give permission to school personnel to share my child's health /medical concerns, past and present, with school personnel on an "as need to know" basis, unless I notify the school nurse in "writing" that I do not want it shared.

Date_____ Parent/Guardian Signature_____

Daytime phone_____ Home Phone_____ Cell Phone_____

Please return this completed form to the school nurse.