



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:

- | | |
|--|---|
| <input type="checkbox"/> Abnormal spinal curvature (Scoliosis, etc)
<input type="checkbox"/> Allergies
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Attention Deficit Disorder
<input type="checkbox"/> Bedwetting at night
<input type="checkbox"/> Wetting during the day
<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Behavior problem
<input type="checkbox"/> Birth defect
<input type="checkbox"/> Cancer, Type _____
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Chronic diarrhea
<input type="checkbox"/> Chronic constipation
<input type="checkbox"/> Stool soiling
<input type="checkbox"/> Concern about relationship with siblings or friends
<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eczema | <input type="checkbox"/> Emotional problems
<input type="checkbox"/> Eye problems
<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Frequent skin infections
<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Heart disease, type _____
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney disease, type _____
<input type="checkbox"/> Meningitis
<input type="checkbox"/> Multiple ear infections (3 or more per year)
<input type="checkbox"/> Near-drowning or near-suffocation
<input type="checkbox"/> Nervous twitches or tics
<input type="checkbox"/> Poisoning
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Seizures or epilepsy
<input type="checkbox"/> Sickle Cell disease
<input type="checkbox"/> Substance abuse (alcohol, drugs)
<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> 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.