

HEALTH HISTORY FORM

This form should be filled out by the child's parent or legal guardian. Return the completed form to your child's school nurse.

Name of Child _____ Date of Birth _____ Sex: Male Female Grade _____ Rm # _____

Address _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1: Name _____ Email _____

Tel # (H) _____ (C) _____ (W) _____

Parent/Guardian #2: Name _____ Email _____

Tel # (H) _____ (C) _____ (W) _____

Emergency contacts: Name _____ Relationship: _____ Telephone #: _____

Name _____ Relationship: _____ Telephone #: _____

MEDICAL HISTORY

Health concerns: Does your child have any health concerns the nurse needs to be aware of? Yes No

If YES, please describe. _____

Can your child participate in all school activities? Yes No

Allergies: Does your child have any allergies? Yes No If YES, what is your child allergic to? _____

Does your child carry an Epi Pen? Yes No

Medication: Does your child currently take medications? Yes No If YES, what medicine? _____

Past medical history: Date of last doctor's visit _____

Does or has your child received medical care for any of the following:

Asthma Diabetes Kidney Disease Orthopedic Other _____

Concussion/Head injury Heart Disease Mental Health Seizure

MEDICAL PROVIDER INFORMATION

Primary care provider: Name _____ Clinic/Practice Name _____

Dentist: Name _____ Clinic/Practice Name _____

Other provider: Name _____ Clinic/Practice Name _____

Health insurance type: Mass Health Private Insurance Other _____

If you do not have a doctor or health insurance: Would you like assistance finding a health care provider? Yes No

Would you like assistance obtaining health care insurance? Yes No

PARENT/GUARDIAN CONSENT

The school nurse has permission to give my child the following **over-the-counter medications**: Acetaminophen (same ingredient as TYLENOL)

Ibuprofen (same ingredient as ADVIL)

The school nurse has permission to share information with school staff as s/he determines appropriate for my child's health and safety. Yes No

The school nurse has permission to share the following information about my child with my child's health care provider:

Childhood immunizations Yes No Mental health/counseling concerns Yes No

Prescribed medications Yes No Other: _____ Yes No

My child's medical conditions Yes No



Parent/Guardian Signature

Please Print Name Here

Date

For Clinical / Office Use Only



Nurse Signature

Please Print Name Here

Date