HEALTH HISTORY FORM
School Health Program

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
Gender
Grade
Rm #

Address

PARENT/GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>Parent/Guardian #1:</th>
<th>Tel # (H)</th>
<th>Email</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<th>Parent/Guardian #2:</th>
<th>Tel # (H)</th>
<th>Email</th>
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<tbody>
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<td>Name</td>
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Emergency contacts:
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<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Telephone</th>
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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
- ☐ Concussion/Head injury
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Mental Health
- ☐ Orthopedic
- ☐ Seizure
- ☐ Other ____________

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 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 and receive the following information about my child with my child’s health care provider:

Prescribed medications ☐ Yes ☐ No My child’s medical conditions ☐ Yes ☐ No

Mental health/counseling concerns ☐ Yes ☐ No Other: ____________

Parent/Guardian Signature ☐ Please Print Name Here Date

School health services are provided to CPS through a collaborative agreement with the Cambridge Public Health Department.

Last revised 10/30/17