Needham Public Schools
School Health Services
Health History

Student Name: ___________________________________ Age: ____ Birth Date: ________
Entering Grade: _________ School ____
Parent/Guardian Name (print) ____
Home Phone Number ___________________ Cell Phone Number ____________________
Home Address: ____________________________________
____
Email Address: ____________________________________

Primary language of family:
English____ Portuguese ____Spanish ____Other ___________________________________

PURPOSE: The Health History Form is a confidential document required for all students entering the Needham Public Schools. Please inform the school nurses of any changes in your child's health during the school year and contact the school nurse with any concerns or questions.

1. ALLERGIES
Does your child have diagnosed allergies? (check all that applies)

	Allergy	Prescribed an EpiPen?	Details about allergy:
Bees/Insects	yes____ no ____	yes ___ no ___	_________________________
Foods	yes____ no ____	yes ___ no ___	_________________________
Medications	yes____ no ____	yes ___ no ___	_________________________
Latex	yes____ no ____	yes ___ no ___	_________________________
Cold	yes____ no ____	yes ___ no ___	_________________________
Other	___________________	yes ___ no ___	_________________________

2. FAMILY HISTORY
Does anyone in your immediate family have a history of asthma, cancer, diabetes, seizures, heart problems, high blood pressure, tuberculosis (TB), color blindness, mental health issues, or other health conditions? Please describe: ____
____

3. GENERAL HEALTH AND DEVELOPMENTAL HISTORY
Does your child have a history of?

	Yes	No	If Yes, please explain
Hospitalizations/surgery	____	____	_____________________________
Birth Defect	____	____	_____________________________
Fainting episodes	____	____	_____________________________
Convulsions/seizures	____	____	_____________________________
Frequent headaches	____	____	_____________________________

	Yes	No	If Yes, please explain
Diagnosed migraines			
Frequent nosebleeds			
Strep throat			
Asthma/wheezing			
Cystic Fibrosis			
Diabetes			
Skin rashes or condition			
Heart murmur			
Heart condition			
Sickle Cell Disease/trait			
Painful menstrual periods			
Orthopedic problems			
Difficulty sleeping			
Nightmares			
Unusual fears			
Aggressive behavior			
Tantrums			
Self injurious behavior			
Dental problems			

Has your child ever been diagnosed with any of the following?

	Yes	No	If Yes, please explain
ADD/ADHD			
Asperger's Syndrome			
Developmental delays			
Pervasive Developmental Disorder (PDD)			
Anxiety			
Depression			
Eating Disorder			

4. EYES

Have you observed your child?

	Yes	No	If Yes, please explain
Crossing or turning eyes			
Squinting			
Complaining of double vision/blurry vision			
Needing to sit close to the television			

Has your child had?

	Yes	No	If Yes, please explain
Corrective lenses or glasses			
Eye surgery			
The need to patch an eye			

Date of last eye exam ____________________

5. EARS

Does your child

	Yes	No	If Yes, please explain
Fail to respond appropriately to directions/instructions	____	____	________________
Fail to respond when you call	____	____	________________
Require repetition of questions/ instruction	____	____	________________
Wear a hearing aid	____	____	________________

Has your child

Had a hearing test	____	____	________________
Been to a hearing specialist	____	____	________________
Been diagnosed with a hearing loss	____	____	________________
Had frequent ear infections	____	____	________________
Had placement of tubes in his/her ears	____	____	________________
Date of last hearing exam	__________		

BOWEL/BLADDER

Does your child have a history of?

	Yes	No	If Yes, please explain
Frequent stomach aches	____	____	________________
A poor appetite/eating difficulty	____	____	________________
Celiac Disease	____	____	________________
Encopresis	____	____	________________
Inflammatory Bowel Disease	____	____	________________
Irritable Bowel Syndrome	____	____	________________
Urinary tract infections	____	____	________________
Bedwetting	____	____	________________
Incontinence of stool	____	____	________________
Incontinence of urine	____	____	________________
Other	____	____	________________

INJURIES

Has your child ever had?

	Yes	No	If Yes, please explain
Any serious accident or trauma	____	____	________________
Broken Bones	____	____	________________
A head injury/concussion	____	____	________________

8. *Is your child taking any medication, daily or as needed? Please list medications and explain reason for medication.*

____
____
____

9. *Have there been any recent changes in your family that may affect your child, such as: birth of sibling, recent death, family illness, employment, housing, military deployment, or change in marital status?*

____
____
____

10. *Briefly describe your child (for example active, shy, strengths, weaknesses, etc). Please include any information that would be helpful for us to know when caring for your child.*

____
____
____

11. *Do you or your child anticipate any challenges upon entering school?*

____
____
____

12. Is your child covered by health insurance? yes____ no_____
Would you like information about State health insurance? yes____ no _____

13. When was your child's last dental appointment? _________________________

14. What other assistance or information that we may provide for you or your child?

____

Signature: ______________________________________ Date completed: __________
Name printed ____________________________________
Relationship to student: __________________________