

WORCESTER PUBLIC SCHOOLS DEPARTMENT OF NURSING

HEALTH HISTORY

Name of Student: _____

Date of Birth: ____/____/____ Grade: _____ Place of Birth: _____

Birth History

Full Term (over 37 weeks): _____

Pre Term (# of weeks gestation): _____

Early Intervention? Yes No

Development Delays: Did your child have any significant

development delays (crawling, walking, talking): Yes No

When? _____

What happened? _____

Allergies: Does your child have any significant allergies (latex, medication, environmental)? Yes No

Has your child ever been stung by a bee or insect Yes No

When? _____

What happened? _____

Are there any foods your child should not eat or is allergic to?

What: _____

Reason: _____

Has your child ever had an allergic reaction to any medication?

Name of medication: _____

Reason on medication? _____

Medication: Is your child taking any medication on a regular basis

at home or in school? Yes No

Name of medication(s): _____

Reason on medication(s)? _____

Will medication be needed at school or on a field trip? Yes No

Which medication(s)? _____

Has your child had any:

Operations Yes No serious Accidents Yes No

Fractured Bones Yes No serious head injury Yes No

Hospitalizations Yes No

Please give dates/details: _____

Does your child have a history of:

Asthma/Wheezing Yes No

Bleeding Disorder Yes No

Bone or joint disease Yes No

Chicken Pox or Shingles Yes No

Diabetes Yes No

Depression Yes No

Frequent nosebleeds Yes No

Headaches: Yes No

Chronic Yes No

Migraine Yes No

Hearing difficulties Yes No

Heart conditions Yes No

High blood pressure Yes No

Skin problems Yes No

Stomach/Bowel problems Yes No

Scoliosis Yes No

Seizure Disorder Yes No

Last seizure? _____

Seizures with fever Yes No

Visual problems Yes No

Urinary problems Yes No

Weight concerns (obesity, eating disorder) Yes No

Other Yes No

Does your child use any of these aids?

Contact lenses Yes No Eyeglasses Yes No

Hearing Aid Yes No Tubes in ears Yes No

Crutches Yes No Wheelchair Yes No

Brace for arm or leg Yes No

Palate expander Yes No

Orthodontic braces/retainer Yes No

Other, please specify: _____

I give health personnel permission to share relevant medical information with school staff, emergency medical personnel and my child's physician.

I give my permission for my child's physician to share health information with the school nurse.

Parent/Guardian Signature

Date

If needed, use the reverse side of the paper to make additional comments. Please call the school nurse to discuss any of the above information or to ask questions. Assistance is also available from the Nursing Administration at 508-799-8554.