



School Health Services

School Health History Record/Update

(Parent/Guardian to complete)

School Year: _____

Student Name: _____ Male _____ Female _____

Date of Birth: _____ Grade: _____

How does this child's development compare to other children, such as brothers/sisters or playmates?

About the same _____ Delayed _____ Advanced _____

Health Conditions: Please check any that your child has or had

Current	Past		Current	Past		Current	Past	
___	___	Allergies	___	___	Cancer	___	___	Hepatitis
___	___	Anaphylactic reaction	___	___	Chickenpox	___	___	Juvenile Arthritis
___	___	Asthma or wheezing	___	___	Cystic Fibrosis	___	___	Meningitis/Encephalitis
___	___	Attention Deficit	___	___	Diabetes	___	___	Seizures/Epilepsy
___	___	Behavior/Emotional concerns	___	___	Ear problems/poor hearing	___	___	Sore throat (frequent)
___	___	Birth/Congenital malformations	___	___	Eczema/skin conditions	___	___	Speech difficulties
___	___	Blood problems	___	___	Eye problems/poor vision	___	___	Toothaches/dental problems
___	___	Bone/Joint problems	___	___	Headache (frequent)	___	___	Urinary tract infections
___	___	Bowel problems	___	___	Heart Disease	___	___	Wetting during day/night

Current Health: Tell us about any current health conditions or concerns.

Illness, Injuries & Hospitalizations (please explain):

Medical Home: Please provide us with your child's current health care provider's name and contact information.

Healthcare Provider/Physician Name: _____ Phone: _____

Address: _____

Student Name: _____

Page 2 of 2

Allergies: If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

Allergy	Reaction	Treatment

Medications: Describe medicine your child takes regularly. If your child must take medication at school, please obtain the Medication Administration Authorization form from the school clinic to be completed by you and your child's healthcare provider.

Medication	Reason	How often?	What time?

Explain any special assistance your child may need during the school day:

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of: _____

Please check with your health care provider to be sure your child's immunizations are all current and up to date. You will be requested to provide an updated copy of immunization records to the school if the records on file with the school are not current.

If you have questions or concerns about your child's health or would like information about a medical home for your child or community services that may be available, please contact your school clinic.

Name of Person Completing Form

Signature

Date