WARWICK SCHOOL DISTRICT

HEALTH HISTORY

_____
Date

Name: _____
Last First Middle

Address: _____

Phone: _____ Birthdate: _____

Father's Name: _____ Mother's Name: _____

Name of School: _____ Grade: _____ Age: _____

HEALTH BACKGROUND

Information relative to your child's health may be shared with appropriate school personnel when necessary to meet your child's educational, health, and safety needs.

1. Please give the dates or approximate age that your child had the following diseases:

   Chicken Pox _____ Pneumonia _____

   Rheumatic Fever _____ Infectious Mononucleosis _____

   Other _____

2. Has your child ever been in the hospital or had an operation**?** **NO** **YES**

   If yes, when? _____ Reason: _____

   _____

3. Has your child had any other illnesses, accidents, or broken bones**?** **NO** **YES**

   If yes, when? _____ What problem? _____

   _____

4. Name of child's doctor or clinic: _____

5. Is your child receiving treatment from a doctor or clinic at present? **NO** **YES**

   If yes, explain: _____

6. Is your child taking medicines? **NO** **YES**

   If yes, what? _____ Why? _____

7. Has your child ever been seen by a dentist? **NO** **YES**

   Name of dentist _____ Date of last visit: _____

8. Is your child restricted from physical activity? **NO** **YES**

   If yes, explain: _____

9. Does your child need special seating in the classroom? **NO** **YES**

   If yes, explain: _____

OVER

SIDE 2

10. Has your child had trouble with any of the following? (see question #12 for additional space to write information)

Ears or Hearing:	**NO**	**YES**:	If yes, explain: _____
Eyes or Vision:	**NO**	**YES**:	If yes, explain: _____
Convulsions or Seizures:	**NO**	**YES**:	If yes, explain: _____
Food Intolerance	**NO**	**YES**:	If yes, explain: _____
Diabetes	**NO**	**YES**:	If yes, provide information on lines #12 and #13 below.
Stomachaches (more than usual)	**NO**	**YES**:	If yes, explain: _____
Asthma	**NO**	**YES**:	If yes, provide information on lines #12 and #13 below.
Bee Sting Sensitivity	**NO**	**YES**:	If yes, describe reaction: _____
Allergies	**NO**	**YES**:	If yes, describe: _____
Colds	**NO**	**YES**:	If yes, explain: _____
Fevers	**NO**	**YES**:	If yes, explain: _____

11. Does your child have any other special health needs or problems not listed above that the school should know about? **NO** **YES**: If yes, explain: _____

_____

12. Please use this space to further explain any of the items mentioned in #10 and #11 as necessary. _____

_____

_____

13. What do you want the school nurse to do about any of the above discussed problems if anything should occur in school?

_____

_____

14. **Tuberculosis (TB) Risk Assessment**: Routine skin testing for tuberculosis in children with no risk factors is not recommended; therefore, the following questions will help to determine whether your child is considered to be at increased risk for acquiring tuberculosis.

1.) Has your child had any contact with an adult with infectious tuberculosis? **NO** **YES**

2.) Were you or your child born, or did you live in a country where TB is common (e.g., Asia, Africa, Caribbean Islands, Latin America, Mexico, Middle East, Philippines, Russian Fed., or South America)? **NO** **YES**

3.) Does your child have any of the following medical risk factors: Diabetes, chronic kidney failure, chronic respiratory disease, or chronic illness associated with malnutrition? **NO** **YES**

4.) Does your child have a disease or receive treatment that affects his or her immune system, such as cancer, leukemia, lymphoma, Hodgkin's disease, or HIV infection? **NO** **YES**

5.) Does your child have frequent contact with persons in any of the following groups: Residents of nursing homes, migrant farm workers, IV drug abusers, HIV positive persons, homeless individuals, or incarcerated persons? **NO** **YES**

Person completing health history _____ Date_____

(Signature)