

# SCHOOL HEALTH HISTORY

Dear Parent,

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to the school Nurse.

Pupil's Name: \_\_\_\_\_ Sex \_\_\_\_\_ D.O.B \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Number of siblings: Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ This child is number \_\_\_\_\_ in family.

1. With whom does the child live? \_\_\_\_\_

2. How is health care provided for this student? Private Health Insurance [ ]  
No Health Insurance [ ] Social Security Insurance [ ] Medicaid [ ]

3. Physician's Name , address and phone \_\_\_\_\_

4. Does your child have a history of any health problems? (Check all that apply)

Asthma \_\_\_\_\_ Allergies \_\_\_\_\_ Hearing or vision difficulties \_\_\_\_\_ Bedwetting \_\_\_\_\_ Seizures \_\_\_\_\_ Other \_\_\_\_\_

Explain: \_\_\_\_\_

5. Does your child take medication? \_\_\_\_\_ If yes, Name and reason for medication \_\_\_\_\_

*\*please note that if your child requires medication at school, all prescription medication must be accompanied by an order from your physicia, and a note from a parent. Please see student Handbook for details.*

6. Is there anything more about your child's health that you think is important for us to know?

\_\_\_\_\_

a. Are there any matters at home that may affect your child's learning? (ie: custody concerns, recent death etc...)

\_\_\_\_\_

---

## New and Transfer students, please also fill out the following:

7. During the pregnancy with this child, did the mother have any medical problems? ( ie: High Blood Pressure, infection, Gestational Diabetes etc...) \_\_\_\_\_

8. During pregnancy, did the mother smoke cigarettes, or drink alcohol? If yes, packs per day. \_\_\_\_\_ drinks per day \_\_\_\_\_.

9. Did mother take any medications other than vitamins or iron? \_\_\_\_\_ If yes, name medication. \_\_\_\_\_

10. Were there complications during Labor and Delivery? (specify) \_\_\_\_\_

- a. How long did the child remain in the hospital after birth? \_\_\_\_\_
- b. Did the child get discharged from the hospital with the mother? \_\_\_\_\_ If no, explain: \_\_\_\_\_
- c. What age did your child: Walk alone \_\_\_\_\_ Talk (2 words together) \_\_\_\_\_
- d. Is your child toilet trained? Is bedwetting a problem? If so, please explain \_\_\_\_\_

11. Does any close relative in the family have a history of: (Check and indicate relationship to child)

Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_  
Birth Defect \_\_\_\_\_ Epilepsy \_\_\_\_\_ Learning Problems \_\_\_\_\_  
Mental Retardation \_\_\_\_\_ Other: \_\_\_\_\_

Please be advised that New Hampshire state law requires all students receive a physical exam and proper immunizations before entering school. Please make your physician's appointment early so your child may enter school on time.

For more information on these requirements, please see the handbook on our website at <http://mason.sau89.org> or the Department of Health and Human Services at <http://www.dhhs.state.nh.us/dphs/immunization/schools.htm> , and the New Hampshire Department of Education at [http://www.education.nh.gov/instruction/school\\_health/index.htm](http://www.education.nh.gov/instruction/school_health/index.htm).

If you have any questions or concerns about this form or requirements, please feel free to call the school Nurse M-F, 9am to 3pm at (603) 878-2962 x18.

***By signing below, I certify to the best of my knowledge that the above information is true and accurate; and for the Health and Safety of my child, the School Nurse may share pertinent information about my child with the appropriate school personnel on a need to know basis.***

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date