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 physician 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…)
   ____

Returning students, please sign back of form.

New and Transfer students, please also fill out the following and sign back of form:

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.

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 confidential and or pertinent information about my child with the appropriate school personnel on a need to know basis. In the event of an emergency, and I cannot be reached, I give the staff of Mason Elementary School permission to call 911 to transfer my child to the hospital.

I prefer my child be taken to:__________________________________ if emergency transport is needed.

(Please specify name of Hospital, or nearest Emergency facility will be used.)

____ ________________________

Parent's Signature **Date**