MASON SCHOOL DISTRICT

NEW STUDENT HEALTH HISTORY

Student's Name: _____ Sex:_____ DOB: _____

Address: _____

Mother's Name: _____ Phone #_____ Father's Name : _____ Phone #_____

Number of Siblings: Brothers _____ Sisters _____ This child is number _____ in Family.

With Whom does the student live? _____

1. How is healthcare provided for this student? Private health insurance ___ No Health insurance ___ Other ___

Physician's Name, City and Phone # _____

2. Does your child have a History or any of the following Health Conditions? (check all that apply)

Allergies ___ Incontinence ____ Seizures ____ Frequent nose bleeds, strep or ear infections ___ Sensitive Skin ____

Asthma____ Vision concerns ____(lenses?) _____ Hearing concerns ____ Tympanostomy tubes ____

Elevated Lead levels ____ Bleeding disorder _____ Cerebral Palsy _____ Learning concerns ____

Explain any above: _____

3. Does your child take any medication? ____ If yes, name and reason(s) for medication(s): _____

_____

**Please note that if your child requires medication at school, all prescription medication must be accompanied by an order from your Physician and a signature from a parent or legal Guardian. Please see the Student Handbook and Medication order forms posted on our website at:* https://mason.sau89.org.*

4. Is there anything more about your child's health that you think is important for us to know? Or matters at home that may affect your child's learning? _____

_____

5. During pregnancy with this child, did the mother have any medical problems? (i.e. High Blood Pressure, infection, Gestational Diabetes etc.) _____

6. Did Mother take any medications other than vitamins or iron, smoke cigarettes or drink alcohol? If so, please explain: _____

7. Were there complications during Labor and Delivery? Please explain _____
   a. How long did the child remain in the hospital after birth? _____
   b. Did child get discharged with mother? _____

8. What age did your child: Walk alone _____ Talk (2 words together) _____
   a. Is your child toilet trained? _____ Is bedwetting a problem? Please explain: _____

9. Does any close relative in the family have a history of: (please indicate relationship to child)
   Diabetes_____ Cancer_____ Epilepsy _____

   Hypertension _____ Birth Defect _____ Learning Problems _____

   *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: https://mason.sau89.org , or the New Hampshire Department of Health and Human Services at: https://www.dhhs.nh.gov/search?keys=school+immunizations

   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 or email at dfisher@sau89.nh.gov

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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 nearest hospital.
I prefer my child be taken to (please specify hospital). _____if emergency transport is needed, and the EMS service can transport there. I acknowledge that nearest facility will be used if transport is not available to the preferred facility.

Parent Signature _____ Date _____

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