

HEALTH HISTORY QUESTIONNAIRE

Child's Name _____

Grade _____

Please check health condition(s) your child has:
conditions

_____ My child has no health

- | | | |
|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problem |
| <input type="checkbox"/> Allergies (see below) | <input type="checkbox"/> Epilepsy/Seizures (see below) | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Asthma (see below) | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Muscular Problem |
| <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bowel or Bladder Disorder | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Orthopedic (Bone) Disorder |
| <input type="checkbox"/> Dental Problem | <input type="checkbox"/> Heart Problem (see below) | <input type="checkbox"/> Throat Infections |

*For conditions checked above, please provide additional information:

_____ Food _____ Reaction _____

_____ Insect _____ Reaction _____

Allergies: _____ Medication _____ Reaction _____

_____ Environmental _____ Reaction _____

_____ Animals _____ Reaction _____

*Is emergency medication needed for allergies? Yes _____ No _____

Epi-pen? Yes _____ No _____ Other medication:

Asthma: _____ Date of last episode: _____ List triggers:

*Medication is needed at school: Daily _____ Before P.E. _____ When symptoms occur _____

Check type: Febrile Only _____ Convulsive _____ Non-Convulsive _____

Seizures:

When did last seizure occur? _____ Medication: _____

Heart Problem: Check type: Functional Heart Murmur _____ Heart valve condition _____

Other: _____ Is exercise limited? Yes _____ No _____

Date of last evaluation _____

Other Condition: _____ Health

Does your child wear glasses? Yes _____ No _____ If yes, please give date of last exam _____

Does your child have other eye problems (crossed eyes, reddened or watery eyes)? Yes _____ No _____

Has your child had tubes inserted into his/her ears to alleviate fluid and ear infections? Yes _____ No _____

Date: _____ Are they currently in place? Yes _____ No _____ Right ear _____ Left ear _____

Check any of the following corrective devices your child wears?

_____ Hearing Aids (R ear, L ear, Both) _____ Dental Appliance/Braces _____ Leg Braces _____ Orthotics

Specify when to be worn: _____

Is your child on a special diet? Yes _____ No _____ If so, please explain _____

Is your child taking medication on a daily basis? Yes _____ No _____ If yes, complete information below

Medication _____ Dosage _____ Reason _____

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Has your child had any serious illnesses? Yes _____ No _____ If yes, please explain _____

_____ Date _____

Has your child been hospitalized or had surgery? Yes _____ No _____ If yes, please explain _____

Date

Has your child had any serious injury or broken bones? Yes _____ No _____ If yes, please explain

_____ Date _____

Has your child ever fainted? Yes _____ No _____

Has your child ever complained of chest pain? Yes _____ No _____

Has your child ever been advised not to participate in any activity or sport? Yes _____ No _____

Has your child faced any emotional experiences over the past year? (examples: parent's separation/divorce, serious illness in the family, death, relocation, remarriage, new baby). Yes _____ No _____

If _____ yes, _____ please _____ explain:

Child's doctor: Name _____ Phone _____

I give my permission to share this medical information with any school personnel who have contact and responsibility for the safety and well being of my child.

Parent/Guardian Signature _____ Date _____