H514.029

INTERVAL OR UPDATE HEALTH HISTORY

Student Name _____ Date of Birth _____

Address _____

Grade _____ School _____

Date _____ **To be completed by Parent/Guardian**

Put A Circle Around Answer

1. Has your child been in good health in the past year? ..... **Yes No**

If no, please explain _____

_____

2. Has your child had any of the following in past years:

a) any illness lasting more than three (3) days ..... **No Yes**

b) any severe injuries or accidents ..... **No Yes**

c) any fractures or broken bones ..... **No Yes**

d) any sprains or strains ..... **No Yes**

e) any time in a hospital ..... **No Yes**

f) any operations ..... **No Yes**

g) any drugs or treatments prescribed by a physician or clinic ..... **No Yes**

If yes to any of the above, please explain _____

_____

_____

3. a) Is your child under the care of a physician or clinic now? ..... **No Yes**

b) Is your child taking any drugs, treatments or medications now? ..... **No Yes**

If yes to either of the above, please explain _____

_____

_____

4. In the past year, have you noticed that your child has any of the following problems:

a) trouble with eyes or seeing ..... **No Yes**

b) begun to wear glasses ..... **No Yes**

c) begun to wear contact lenses ..... **No Yes**

d) trouble with ears or hearing ..... **No Yes**

e) trouble with allergies ..... **No Yes**

f) trouble with asthma or breathing ..... **No Yes**

g) trouble with eating or with weight gain or loss ..... **No Yes**

h) trouble with sleeping ..... **No Yes**

i) trouble keeping up with the activities of his/her friends ..... **No** **Yes**

j) trouble with class work ..... **No** **Yes**

k) trouble with school ..... **No** **Yes**

l) trouble with the family ..... **No** **Yes**

m) problem with general development and maturity ..... **No** **Yes**

If yes to any of the above, please explain _____

_____

_____

5. **a) Has your child seen a dentist in the past year?** ..... **No** **Yes**

b) How would you describe the state of your child's teeth: **Circle Those Which Apply**

Teeth Missing ..... **None** **Some** **All**

Teeth Decayed (cavities) ..... **None** **Some** **All**

Teeth Filled ..... **None** **Some** **All**

6. **Has your child had any immunizations in the past year?** ..... **No** **Yes**

If yes, please explain _____

_____

_____

Has your child received the following immunizations:

Three (3) or more doses of Diphtheria and Tetanus ..... **No** **Yes**

Three (3) or more doses of Polio ..... **No** **Yes**

One (1) dose of Measles ..... **No** **Yes**

One (1) dose of Rubella (German Measles) ..... **No** **Yes**

7. **Has any member of the family developed any serious health problem in the past year?** ..... **No** **Yes**

If yes, please explain _____

_____

_____

8. **Do you think your child is fit to participate in all school sports, athletics and gym class?** ..... **No** **Yes**

If no, please explain _____

_____

_____

9. **Do you have any concerns regarding your child which you would like to discuss with a nurse or physician?** ..... **No** **Yes**

If yes, the School Nurse Practitioner will contact you to set up an appointment.