

OFFICE OF SCHOOL NURSE
Windham, NH

HEALTH HISTORY

Print Student's Name: _____

Previous Illnesses: _____

Previous Operation: _____

Speech Problems: _____

Vision Problems: _____

Has the student had a vision screening in the last year at doctor's office?

No____ Yes____

Hearing Problems: _____

History of Ear Infections No____ Yes____

Tubes No____ Yes____

Has the student had a hearing screening in the last year at the doctor's office?

No____ Yes____

ALLERGIES (food, bee stings, medications, etc.) _____

Does this student have an Rx for an EpiPen? No____ Yes____

Has your student had Chicken Pox? No____ Yes____ Year____

Asthma: No____ Yes____

Skin Conditions (hives, eczema): _____

Heart Disease: No____ Yes____

Blood Born Pathogens (Hep. B/HIV etc.): _____

Kidney Infections: No____ Yes____

Diabetes: No____ Yes____

Convulsions or Seizures: _____

Tuberculosis: No____ Yes____

Has constipation or diarrhea ever been a problem? _____

Physical Handicaps: _____

Orthopedic problems or restrictions (feet, legs, etc.) _____

Was pre-natal period and birth considered normal? No____ Yes____

If no, please explain _____

Parent Signature

Date