WARWICK SCHOOL DISTRICT

HEALTH HISTORY

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Date

Name: ____
Last First Middle

Address: ____

Phone: ______________________ Birthdate: ______________________

Father's Name: ______________________ Mother's Name: ______________________

Name of School: ______________________ Grade: __________ Age: __________

HEALTH BACKGROUND

Information relative to your child's health may be shared with appropriate school personnel when necessary to meet your child's educational, health, and safety needs.

1. Please give the dates or approximate age that your child had the following diseases:

   Chicken Pox __________ Pneumonia __________

   Rheumatic Fever __________ Infectious Mononucleosis __________

   Other ____

2. Has your child ever been in the hospital or had an operation**?** **NO** **YES**

   If yes, when? ______________________ Reason: ______________________

   ____

3. Has your child had any other illnesses, accidents, or broken bones**?** **NO** **YES**

   If yes, when? ______________________ What problem? ______________________

   ____

4. Name of child's doctor or clinic: ____

5. Is your child receiving treatment from a doctor or clinic at present? **NO** **YES**

   If yes, explain: ____

6. Is your child taking medicines? **NO** **YES**

   If yes, what? ______________________ Why? ______________________

7. Has your child ever been seen by a dentist? **NO** **YES**

   Name of dentist ______________________ Date of last visit: ______________________

8. Is your child restricted from physical activity? **NO** **YES**

   If yes, explain: ____

9. Does your child need special seating in the classroom? **NO** **YES**

   If yes, explain: ____

OVER

SIDE 2

10. Has your child had trouble with any of the following? (see question #12 for additional space to write information)

Ears or Hearing:	**NO**	**YES**:	If yes, explain: ________________
Eyes or Vision:	**NO**	**YES**:	If yes, explain: ________________
Convulsions or Seizures:	**NO**	**YES**:	If yes, explain: ________________
Food Intolerance	**NO**	**YES**:	If yes, explain: ________________
Diabetes	**NO**	**YES**:	If yes, provide information on lines #12 and #13 below.
Stomachaches (more than usual)	**NO**	**YES**:	If yes, explain: ________________
Asthma	**NO**	**YES**:	If yes, provide information on lines #12 and #13 below.
Bee Sting Sensitivity	**NO**	**YES**:	If yes, describe reaction: ________________
Allergies	**NO**	**YES**:	If yes, describe: ________________
Colds	**NO**	**YES**:	If yes, explain: ________________
Fevers	**NO**	**YES**:	If yes, explain: ________________

11. Does your child have any other special health needs or problems not listed above that the school should know about? **NO** **YES**: If yes, explain: ________________

____

12. Please use this space to further explain any of the items mentioned in #10 and #11 as necessary. ___________

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13. What do you want the school nurse to do about any of the above discussed problems if anything should occur in school?

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14. **Tuberculosis (TB) Risk Assessment**: Routine skin testing for tuberculosis in children with no risk factors is not recommended; therefore, the following questions will help to determine whether your child is considered to be at increased risk for acquiring tuberculosis.

1.) Has your child had any contact with an adult with infectious tuberculosis? **NO** **YES**

2.) Were you or your child born, or did you live in a country where TB is common (e.g., Asia, Africa, Caribbean Islands, Latin America, Mexico, Middle East, Philippines, Russian Fed., or South America)? **NO** **YES**

3.) Does your child have any of the following medical risk factors: Diabetes, chronic kidney failure, chronic respiratory disease, or chronic illness associated with malnutrition? **NO** **YES**

4.) Does your child have a disease or receive treatment that affects his or her immune system, such as cancer, leukemia, lymphoma, Hodgkin's disease, or HIV infection? **NO** **YES**

5.) Does your child have frequent contact with persons in any of the following groups: Residents of nursing homes, migrant farm workers, IV drug abusers, HIV positive persons, homeless individuals, or incarcerated persons? **NO** **YES**

Person completing health history ________________________ **Date**________________

(Signature)