

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
HEALTH SERVICES
HEALTH HISTORY FORM FOR STUDENTS

Student's name _____ School _____ Grade _____

Address _____ Home Phone _____

Date of Birth _____ Place of Birth _____ Sex M ___ F ___

Mothers Name _____ Address _____ Phone _____

Mothers Place of Employment _____ Work Phone _____

Fathers Name _____ Address _____ Phone _____

Fathers Place of Employment _____ Work Phone _____

Physician _____ Dentist _____

Emergency: 1. Name _____ Phone _____

2. Name _____ Phone _____

**Please check YES or NO for questions below so that our School Health Service may best serve your child.
Explain any yes answers in the space provided on the back of the form.**

HAS YOUR CHILD EVER HAD:

SKIN	yes	no	date	GASTROINTESTINAL	yes	no	date
Lesions	___	___	___	Jaundice	___	___	___
Rashes	___	___	___	Stomach Disorders	___	___	___
EYE PROBLEMS				Frequent Abdominal pain	___	___	___
Vision loss-Rt eye ___ Lt eye ___				Ulcers	___	___	___
Amblyopia- Rt eye ___ Lt eye ___				MUSCULOSKELETAL	___	___	___
Glasses	___	___	___	Arthritis	___	___	___
Contact lenses	___	___	___	Joint pains	___	___	___
Hearing loss – Rt ear ___ Lt ear ___				Limb or back deformities	___	___	___
Ear tubes - Rt ear ___ Lt ear ___				Fracture (broken bone)	___	___	___
Infections	___	___	___	Dislocation	___	___	___
Frequent nose bleeds	___	___	___	Scoliosis	___	___	___
Nose fracture/surgery	___	___	___	Chronic sprains	___	___	___
SORE THROAT				Recurrent injuries	___	___	___
Tonsillitis	___	___	___	GENITOURINARY			
Strep throat	___	___	___	Hernia	___	___	___
Scarlet fever	___	___	___	Bladder or kidney disorder	___	___	___
Tonsils/adenoids removed	___	___	___	Infections	___	___	___
DENTAL PROBLEMS				Testicles: injury/surgery	___	___	___
Braces	___	___	___	Menstruation	___	___	___
Capped teeth	___	___	___	date began _____			
Bridge/loss of teeth	___	___	___	Problems _____			
CARDIOVASCULAR				NEUROLOGICAL			
High Blood Pressure	___	___	___	Headaches	___	___	___
Rheumatic fever	___	___	___	Head injuries	___	___	___
Heart Murmur	___	___	___	Concussions	___	___	___
Heart Surgery	___	___	___	Convulsions	___	___	___
Cardiac Workup	___	___	___	Seizure Disorder	___	___	___
LUNGS/RESPIRATORY				Fainting/blackouts	___	___	___
Asthma	___	___	___	Paralysis/numbness	___	___	___
Allergies	___	___	___	Hyperactivity	___	___	___
Hives	___	___	___	ENDOCRINE			
Hayfever	___	___	___	Diabetes	___	___	___
Pneumonia	___	___	___	Hypoglycemia	___	___	___
Bronchitis	___	___	___	Thyroid Condition	___	___	___
Tuberculosis	___	___	___	COMMUNICABLE DISEASES			
				Measles	___	___	___
				Chicken Pox	___	___	___
				Mononucleosis	___	___	___
				HEMATOLOGY			
Hepatitis A yes ___ no ___ date ___				Hepatitis B yes ___ no ___ date ___			
Anemia yes ___ no ___ date ___				Bleeding disorders yes ___ no ___ date ___			
Sickle Cell Anemia yes ___ no ___ date ___				Transfusions yes ___ no ___ date ___			

PLEASE CONTINUE ON OTHER SIDE

PLEASE LIST ALL MEDICATIONS YOUR CHILD WILL NEED AT SCHOOL:

All medications have side effects and for your child's safety it is important for the School Nurse to have this information.

MEDICATION

DOSE

TIMES

PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES AT HOME:

HAS YOUR SON/ DAUGHTER:

Ever been a patient in a hospital?

Explain _____

Had any operations? Explain _____

Had any accidents? Explain _____

Is your son/daughter under a physicians care now? _____

Is he/she allergic to any medication? _____

Has he/she had any psychological testing? _____

EXPLAIN YES ANSWERS HERE:

COMMENTS: _____

PARENT OR GUARDIAN SIGNATURE

DATE

Please contact the Health Office if you have any questions or if we may be of any service to you and your family.

SCHOOL NURSE

SCHOOL

TELEPHONE