

# Canton Public Schools – Health History

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Grade: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

## Birth History

Full Term (over 37 weeks): \_\_\_\_\_

Pre Term (# of weeks gestation): \_\_\_\_\_

Early Intervention? Yes  No

**Developmental Delays:** Did your child have any significant developmental delays (crawling, walking, talking)? Yes  No

When? \_\_\_\_\_

What happened? \_\_\_\_\_

\_\_\_\_\_

**Allergies:** Does your child have any significant allergies (latex, medication, environmental)? Yes  No

Has your child ever been stung by a bee or insect? Yes  No

When? \_\_\_\_\_

What happened? \_\_\_\_\_

Are there any foods your child should not eat or is allergic to:

What: \_\_\_\_\_

Reason: \_\_\_\_\_

Has your child ever had an allergic reaction to any medication?

Name of medication: \_\_\_\_\_

What happened? \_\_\_\_\_

**Medication:** Is your child taking any medication on a regular basis at home or in school? Yes  No

Name of medications: \_\_\_\_\_

For what reason? \_\_\_\_\_

\_\_\_\_\_

Will medication be needed at school or on a field trip? Yes  No

Which medications? \_\_\_\_\_

## Has your child had any:

Operations Yes  No  Serious accidents Yes  No

Fractured bones Yes  No  Serious head injury Yes  No

Hospitalizations Yes  No  Yes  No

Please give dates/details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Does your child have a history of:

Asthma/Wheezing Yes  No

Bleeding disorder Yes  No

Bone or joint disease Yes  No

Chicken Pox or Shingles Yes  No

Diabetes Yes  No

Depression Yes  No

Frequent nosebleeds Yes  No

Headaches: Yes  No

Chronic Yes  No

Migraine Yes  No

Hearing difficulties Yes  No

Heart conditions Yes  No

High blood pressure Yes  No

Skin problems Yes  No

Stomach/Bowel problems Yes  No

Scoliosis Yes  No

Seizure Disorder Yes  No

Last Seizure? \_\_\_\_\_

Seizures with fever Yes  No

Visual problems Yes  No

Urinary problems Yes  No

Weight concerns (obesity, eating disorder) Yes  No

Other Yes  No

## Does your child use any of these aids?

Contact lenses Yes  No  Eye glasses Yes  No

Hearing aid Yes  No  Tubes in ears Yes  No

Crutches Yes  No  Wheelchair Yes  No

Brace for arm or leg Yes  No

Palate expander Yes  No

Orthodontic braces/retainer Yes  No

Other, please specify: \_\_\_\_\_

I give health personal permission to share relevant medical information with school staff, emergency medical personnel and my child's physician.

Parent/Guardian Signature

Date

Please call the school nurse to discuss any of the above information or to ask questions. If needed, use the reverse side of the paper to make additional comments.