

Canton Public Schools – Health History

Name of Student: _____

Date of Birth: ____/____/____ Male ____ Female ____

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

Does your child have an Epi-Pen 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 <input type="checkbox"/> No <input type="checkbox"/> | Serious accidents | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Fractured bones | Yes <input type="checkbox"/> No <input type="checkbox"/> | Concussion | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hospitalizations | Yes <input type="checkbox"/> No <input type="checkbox"/> | Serious head injury | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Please give dates/details _____

Does your child have a history of:

| | |
|--|--|
| ADD/ADHD | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Is he/she aware of the diagnosis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma/Wheezing | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bleeding disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Bone or joint disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chicken Pox or Shingles | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Depression | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Frequent nosebleeds | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Headaches: | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chronic | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Migraine | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hearing difficulties | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart conditions | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High blood pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Skin problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stomach/Bowel problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Scoliosis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Seizure Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Last Seizure? _____ | |
| Seizures with fever | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Visual problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Urinary problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Weight concerns (obesity, eating disorder) | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Other | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Does your child use any of these aids?

| | | | |
|------------------------------|--|---------------|--|
| Contact lenses | Yes <input type="checkbox"/> No <input type="checkbox"/> | Eye glasses | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Hearing aid | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tubes in ears | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Crutches | Yes <input type="checkbox"/> No <input type="checkbox"/> | Wheelchair | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Brace for arm or leg | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Palate expander | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Orthodontic braces/retainer | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 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.