SUMMIT PUBLIC SCHOOLS
HEALTH HISTORY QUESTIONNAIRE

Dear Parent/ Legal Guardian:
We would like your child to gain the most from his/her school experience. The following information will help the school nurse better understand your child, and assist in the transition to school. If your child has a special health care concern that will require further conversation, please call the school nurse to schedule a meeting.

Student's Name_____ **Birth date**_____

Pregnancy/Birth History:
Full term pregnancy: Yes ( ) No( ) Complications of delivery: Yes ( ) No ( )
If yes, explain_____
Was there any medical concerns immediately after birth: Yes ( ) No ( )
If yes, explain_____

Developmental History: *(circle the one that applies)*

Sat alone:	early	average	area of concern*
Crawled:	early	average	area of concern*
Walked alone	early	average	area of concern*
Toilet trained	early	average	area of concern*
Fed self	early	average	area of concern*
Dressed self	early	average	area of concern*
Spoke first words	early	average	area of concern*
Spoke sentences	early	average	area of concern*

Explain any areas of concern:_____

Health History/ Health Concerns: *(circle yes or no. * Please explain any yes answers below)*

ADD (Attention Deficit Disorder)	yes	no	
Allergies	yes	no	
Asthma/ Reactive Airway Disease	yes	no	
Autism Spectrum Disorder/Aspergers	yes	no	
Behavior/Emotional Concerns	yes	no	
Bleeding disorders	yes	no	
Bone/Joint/Muscle Concerns	yes	no	
Bladder or Kidney Concerns	yes	no	
Bowel Concerns (constipation, loose stools)	yes	no	
Chicken Pox Disease (note month/year)	yes	no	date_____
Concussion (head injuries)	yes	no	date_____
Diabetes	yes	no	
Digestive Concerns / Special Diet	yes	no	
Emotional Concerns	yes	no	
Frequent Ear Infections (? Tubes)	yes	no	
Ear or Hearing Concerns	yes	no	

Health History/Health Concerns (continued):

Eye or Vision Concerns	yes	no	
Wears glasses	yes	no	
Feeding Concerns (aspiration, gagging, drooling)	yes	no	
Gastroesophageal Reflux	yes	no	
Genetic Disorders	yes	no	
Growth Concerns (over/underweight, short stature)	yes	no	
Heart/ Congenital Heart Defect/Heart Murmur	yes	no	
Headaches or Migraines	yes	no	
Hormone Deficiency (thyroid, growth, adrenal, other)	yes	no	
Immune Deficiency	yes	no	
Metabolic Disorder	yes	no	
Neurological Disorder	yes	no	
Nosebleeds frequently	yes	no	
Respiratory infections frequently	yes	no	
Seizure (febrile or otherwise)	yes	no	
Sickle Cell Anemia	yes	no	
Sleep Concerns	yes	no	
Strep Throat (scarlet fever, rheumatic fever)	yes	no	
Surgeries / Hospitalizations	yes	no	date_____
Tourettes Syndrome	yes	no	
Other	yes	no	

*If you answered YES to any of the above, please explain:_____

_____

_____

Current Health Status:

Does your child have any allergies? Yes no Are these allergies life threatening? yes no

If yes, describe_____

_____

Is your child currently taking medication? (include vitamins and meds taken as needed, such as Albuterol, EpiPen)_____

Has your child ever been evaluated for Early Intervention Services?	yes	no	
Has your child ever been evaluated for a learning disability?	yes	no	if yes, when_____
Has your child ever been classified?	Yes	no	if yes, when_____
Has your child ever been evaluated for speech therapy?	Yes	no	if yes, when_____

Family Doctor/Practitioner *(name/address/phone)*:_____

Family Dentist *(name/address/phone)*:_____

I give permission for the school nurse to share the above information about my child with school staff who works directly with my child. yes_____ no_____

Signature of Parent/ Guardian_____Date:_____

11/2010