Cambridge Public Health Department

Health History Form

School Health Program

RETURN

This form should be filled out by the child's PARENT/GUARDIAN/CAREGIVER. Return the completed form to your child's school nurse.

Name of Child__________________ Date of Birth__________ Gender___ Grade___ Rm #___

Address____

• • • • • PARENT/GUARDIAN/CAREGIVER INFORMATION • • • • •

Parent/Guardian/Caregiver #1: Name__________________________

Email__________________ Tel # (H)__________ (C)__________ (W)__________

Parent/Guardian/Caregiver #2: Name__________________________

Email__________________ Tel # (H)__________ (C)__________ (W)__________

Emergency Contacts: Name__________________ Relationship__________ Tel #__________

Name__________________ Relationship__________ Tel #__________

• • • • • MEDICAL HISTORY • • • • •

Health Concerns: Does your child have any health concerns the nurse needs to be aware of? ❍ Yes ❍ No

If YES, please describe: __________________________

Can your child participate in all school activities? ❍ Yes ❍ No

Allergies: Does your child have any allergies? ❍ Yes ❍ No If YES, what is child allergic to?__________

Does your child carry an Epi Pen? ❍ Yes ❍ No

Medication: Does your child currently take medications? ❍ Yes ❍ No

If YES, what medicine(s)?__________________________

Has Your Child Received the COVID-19 Vaccine? ❍ Yes ❍ No If YES, dates__________Type__________

Past Medical History: Date of last doctor's visit __________

Does or has your child received medical care for any of the following:

❍ Asthma ❍ Diabetes ❍ Kidney Disease ❍ Orthopedic ❍ Other

❍ Concussion/Head Injury ❍ Heart Disease ❍ Mental Health ❍ Seizure

• • • • • MEDICAL PROVIDER INFORMATION • • • • •

Primary Care Provider: Name__________________ Clinic/Practice Name __________

Dentist: Name__________________ Clinic/Practice Name __________

Other Provider: Name__________________ Clinic/Practice Name __________

Health Insurance Type: ❍ Mass Health ❍ Private Insurance ❍ Other__________

If you do not have a doctor or health insurance:

Would you like assistance finding a health care provider? ❍ Yes ❍ No

Would you like assistance obtaining health care insurance? ❍ Yes ❍ No

• • • • • PARENT/GUARDIAN/CAREGIVER CONSENT • • • • •

The school nurse has permission to share information with school staff as s/he determines appropriate for my child's health and safety. ❍ Yes ❍ No

The school nurse has permission to share and receive the following information about my child with my child's healthcare provider:

Prescribed medications: ❍ Yes ❍ No My child's medical conditions: ❍ Yes ❍ No

Mental health/counseling concerns: ❍ Yes ❍ No Other: __________________

Parent/Guardian/Caregiver Signature: __________________________

Print Name: __________________________ **Date:** __________

School health services are provided to CPS through a collaborative agreement with the Cambridge Public Health Department.