FORM 3

HEALTH HISTORY FORM

School Health Program

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:_____ Telephone #:_____

Name_____ Relationship:_____ Telephone #:_____

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 your 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?_____

Past medical history: Date of last doctor's visit _____ Date of last dental visit _____

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

☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Other

☐ Concussion/Head injury ☐ Heart Disease ☐ Mental Health ☐ Orthopedic ☐ 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 _____ ☐ Dental_____

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

Would you like assistance finding a dentist or dental 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

Mental health/counseling concerns ☐ Yes ☐ No

My child's medical conditions ☐ Yes ☐ No

Other: _____

Parent/Guardian/Caregiver Signature	Please Print Name Here	Date
_____	_____	_____

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