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_____________ 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)?____

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.