



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:

- | | | | | |
|--|-------------------------------------|--------------------------------------|----------------------------------|-----------------------------|
| <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease | <input type="radio"/> Orthopedic | <input type="radio"/> Other |
| <input type="radio"/> Concussion/Head Injury | <input type="radio"/> Heart Disease | <input type="radio"/> Mental Health | <input type="radio"/> 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: _____