

Rochester School Health Services
Health History

Student's Name _____ Date of Birth ____/____/____ Sex _____
Doctor's Name _____ Phone: _____

My child's health information may be shared with those people who work with my child if it affects their medical care or education. If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

Does your child have any allergies? ____ If yes, explain to what, how they react and how it is treated. _____

Does your child have now (or in the past) any ear/hearing problems? ____ If yes, explain. _____

Has your child had Chicken Pox? ____ **If Yes, give age, date/year, or Lab Test results (required for grds K-3)**

Is your child on any medications? ____ If yes, give the name of medication, when taken & reason:

Is your child presently under medical care? ____ If yes, explain:

Has your child experienced any emotional trauma? ____ If yes, explain. _____

Is there any reason your child cannot participate in a full program of activities at school? ____ If yes, explain _____

Please check any of the following your child has/had:

- | | | |
|-------------------------------------|------------------------------------|-------------------------|
| _____ RAD (Reactive Airway Disease) | _____ Asthma | _____ ADD/ADHD |
| _____ Orthopedic Problems | _____ Seizure Disorder/convulsions | _____ Behavioral Issues |
| _____ Serious Illness/Injuries | _____ Diabetes | _____ Skin Disorder |
| _____ Heart Disease | _____ Surgery (operations) | _____ Nutritional |

Concerns
_____ Hospitalizations

Please give us more information about any of the items you have checked above: _____

Are there any other concerns or chronic health conditions you would like to mention? _____

Health history completed by: _____ Date completed ____/____/____