Falmouth Public Schools

HEALTH HISTORY FOR ENTERING STUDENTS

Student Name: _____Grade ___ DOB: _____ Male____ Female____ Non-Binary____

Physician: _____ Dentist: _____

MEDICAL HISTORY

Were there any significant problems during the pregnancy/labor/delivery? _____

_____

Was the student premature? Yes No How many weeks? _____ Birth Weight? _____

Complications? _____

Has your child had any of the following diseases/conditions? (circle)

ADD/ADHD	Diabetes	Kidney Disease
Anxiety	Ear Infections	Lyme Disease
Asthma	Eczema	Migraine Headaches
Constipation	Elevated lead level	Nose Bleeds
Depression	Heart Disease	Seizures

Other: _____

Surgeries: Yes No Reason: _____ Date: _____

Hospitalized: Yes No Reason: _____ Date: _____

EYES

Vision problems? Yes No Explain _____ Glasses? Yes No Contacts? Yes No

EARS

Hearing problems? Yes No Explain _____Tubes? Yes No Hearing Aids? Yes No

SLEEP AND DIET

Concerns about sleep habits? Yes No Explain _____

Concerns about eating habits? Yes No Explain _____

ALLERGIES

Food Allergies? Yes No Food _____ Symptom _____

Food _____ Symptom _____

Food _____ Symptom _____

Food _____ Symptom _____

Medication Allergies? Yes No Medication_____ Symptom _____

Medication _____ Symptom _____

Other Allergies _____

Does your child use an Epi pen? _____

MEDICATIONS

Medication _____ Reason _____ Time of Day _____

Medication _____ Reason _____ Time of Day _____

Medication _____ Reason _____ Time of Day _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel as necessary to meet my child's health and safety needs. I give permission to exchange information with my child's physician(s) for the purpose of referral, diagnosis, treatment and to obtain a copy of the most recent physical examination/immunization record.

Parent/Guardian Signature _____ Date _____