WORCESTER PUBLIC SCHOOLS
DEPARTMENT OF NURSING

HEALTH HISTORY

Name of Student: _____

Date of Birth: ____/_____/_____ Grade: _____Place of Birth: _____

Birth History

Full Term (over 37 weeks):_____

Pre Term (# of weeks gestation):_____

Early Intervention? Yes ☐ No ☐

Development Delays: Did your child have any significant development delays (crawling, walking, talking): Yes ☐ No ☐

When?_____

What happened? _____

_____

Allergies: Does your child have any significant allergies (latex, medication, environmental)? Yes ☐ No ☐

Has your child ever been stung by a bee or insect Yes ☐ No ☐

When? _____

What happened? _____

Are there any foods your child should not eat or is allergic to?

What: _____

Reason: _____

Has your child ever had an allergic reaction to any medication?

Name of medication: _____

Reason on medication? _____

_____

_____

Medication: Is your child taking any medication on a regular basis at home or in school? Yes ☐ No ☐

Name of medication(s): _____

Reason on medication(s)? _____

_____

_____

Will medication be needed at school or on a field trip? Yes ☐ No ☐

Which medication(s)? _____

Has your child had any:

Operations Yes ☐ No ☐ serious Accidents Yes ☐ No ☐

Fractured Bones Yes ☐ No ☐ serious head injury Yes ☐ No ☐

Hospitalizations Yes ☐ No ☐

Please give dates/details: _____

_____

Does your child have a history of:

Asthma/Wheezing	Yes ☐ No ☐
Bleeding Disorder	Yes ☐ No ☐
Bone or joint disease	Yes ☐ No ☐
Chicken Pox or Shingles	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐
Depression	Yes ☐ No ☐
Frequent nosebleeds	Yes ☐ No ☐
Headaches:	Yes ☐ No ☐
Chronic	Yes ☐ No ☐
Migraine	Yes ☐ No ☐
Hearing difficulties	Yes ☐ No ☐
Heart conditions	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐
Skin problems	Yes ☐ No ☐
Stomach/Bowel problems	Yes ☐ No ☐
Scoliosis	Yes ☐ No ☐
Seizure Disorder	Yes ☐ No ☐
Last seizure? _____	
Seizures with fever	Yes ☐ No ☐
Visual problems	Yes ☐ No ☐
Urinary problems	Yes ☐ No ☐
Weight concerns (obesity, eating disorder)	Yes ☐ No ☐
Other	Yes ☐ No ☐

Does your child use any of these aids?

Contact lenses Yes ☐ No ☐ Eyeglasses Yes ☐ No ☐

Hearing Aid Yes ☐ No ☐ Tubes in ears Yes ☐ No ☐

Crutches Yes ☐ No ☐ Wheelchair Yes ☐ No ☐

Brace for arm or leg Yes ☐ No ☐

Palate expander Yes ☐ No ☐

Orthodontic braces/retainer Yes ☐ No ☐

Other, please specify: _____

I give health personnel permission to share relevant medical information with school staff, emergency medical personnel and my child's physician.

I give my permission for my child's physician to share health Information with the school nurse.

_____

Parent/Guardian Signature Date

If needed, use the reverse side of the paper to make additional comments. Please call the school nurse to discuss any of the above information or to ask questions. Assistance is also available from the Nursing Administration at 508-799-8554.