Health Information Form

Child's Name_____ **Primary Language at Home**_____
Child's Birthdate_____ **Age** _____ **Grade** _____
Name of Primary Health Care Provider: _____ **Approximate date of last exam:** _____
Has child been seen by a specialist: ☐ Yes ☐ No
Medical Insurance: ☐ Private ☐ Medi-Cal ☐ Healthy Families ☐ None
Who is filling out this form?
☐ Mother ☐ Father Your Name_____
☐ Other (please explain relationship to child)_____

MEDICAL HISTORY

1. Has your child ever been a **patient in a hospital** (other than a few days after birth)?
☐ No (If no, go to question #2.)
☐ Yes (If yes, explain why and when below.)

My child was in the hospital because:	**When**

2. Does your child taking any **prescription medicines**? ☐ Yes - Please list the child's medicines below
Does your child use an inhaler or breathing treatments? ☐ Yes ☐ No If **YES**, please list medicine below.
☐ No, my child does not take any prescription medicines. (If no, go to question #3)

Name of medicine	**Amount/ Dose of pill(s)**	**How many pills or doses does your child take at:**
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed

3. What **over-the-counter medicines** does your child take **regularly**?
☐ Vitamins
☐ Herbal medicine (please list) _____
☐ Other medicines like Tylenol, Advil or something else? (please list)_____
_____
☐ **None**, my child does not take any over-the-counter medicines regularly.

4. Does your child have any **allergic reaction** (bad effect) from any of the following? (**Check all that apply**.)
☐ Outside or Indoor allergies, (*for example: hayfever, grass, pollen, cats …*) **Please list below ↓**
☐ Food Allergies (*for example: peanuts, milk, wheat …)* **Please list below ↓**
☐ Insect or Animal Allergies (*for example: bees, wasps, cats…)* **Please list below ↓**
☐ Medicine or shots (*immunization*). **Please list below ↓**
☐ **No**, my child has no allergies that I know of.
Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

My child is allergic/sensitive to:	**What happens when your child has a reaction?**

5. Has your child had any of the following **medical problems or injuries**? (examples in parenthesis)
Describe **your child's** problem for each ☒**Yes** on the line after the appropriate condition.

ADD/ADHD *(problems paying attention, sitting still)*		☐Yes ☐ No
Autism		☐Yes ☐ No
Back problems *(crooked back, back pain)*		☐Yes ☐ No
Birth defect(s)		☐Yes ☐ No
Breathing problems *(cough, **asthma**)*		☐Yes ☐ No
Chicken Pox--Date if had chickenpox:		☐ Yes ☐ No
Constipation *(problems having a bowel movement (BM))*		☐Yes ☐ No
Dental problems		☐Yes ☐ No
Diabetes		☐Yes ☐ No
Ear infections *(often has them, ear tubes, etc)*		☐ Yes ☐ No
Eating (over or under eating, picky, special diet)		☐ Yes ☐ No
Eye problems *(blurry vision, wears glasses, lazy eye)*		☐Yes ☐ No
Fever over 103.0		☐Yes ☐ No
Head Injury or **Concussion**		☐ Yes ☐ No
Headaches (frequent, migraine)		☐Yes ☐ No
Hearing problems *(has trouble sometimes, wears hearing aid)*		☐Yes ☐ No
Heart problems *(fast or irregular heart beat, murmur, birth defect)*		☐Yes ☐ No
Hospitalization		☐Yes ☐ No
Mental Health Issue (*depression, anxiety, fears)*		☐Yes ☐ No
Mobility: Gross or Fine Motor problems	**Age Crawling: Walking:**	☐Yes ☐ No
Mouth or throat problems *(Strep throat, swallowing problems)*		☐Yes ☐ No
Muscle and bone problems *(weak muscles, pain in joints)*		☐Yes ☐ No
Nose problems *(sinus infections, nose bleeds)*		☐Yes ☐ No
Problems **peeing** *(bed wetting, pain when peeing)*	**Age of toilet training**:	☐Yes ☐ No
Seizures *(shaking fits, convulsions, epilepsy)*		☐Yes ☐ No
Skin problems *(acne, flaking skin, rashes, hives)*		☐Yes ☐ No
Sleeping problems		☐Yes ☐ No
Speech or Language difficulties	**Age of First Word:**	☐Yes ☐ No
Stomachaches		☐Yes ☐ No
Surgery --Date of any surgeries:		☐Yes ☐ No
Unconsciousness		☐Yes ☐ No
Vision----Should **wear glasses or contacts** to see ☐ distance ☐ read		☐Yes ☐ No
Other:		☐Yes ☐ No

_____ _____

Signature of person filling out form Date filled out

** Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*