

D.C. EVEREST SCHOOL DISTRICT STUDENT HEALTH HISTORY

Child's Name: _____ Sex: Male/Female Date: _____
 School: _____ Date of Birth: _____ Age: _____
 Parent/Guardian: _____ Address: _____
 Home Phone Number: _____ Work Phone Number: _____ (Mom)
 _____ (Dad)
 Physician: _____ Phone Number: _____
 Dentist: _____ Phone Number: _____
 Birth Weight: 5-10 lbs. 3-5 lbs. Less than 2 lbs.
 Present Weight: _____ Present Height: _____

GENERAL HEALTH: Please indicate if your child has had problems with the following conditions:

COMMUNICABLE DISEASES:

Chicken pox Y/N Age: _____
 Mumps Y/N Age: _____
 Whooping cough Y/N Age: _____
 Hepatitis Y/N Age: _____
 Measles Y/N Age: _____

REOCCURRANT INFECTIONS:

Colds Y/N Frequency: _____
 Sore throat-
 strep infection Y/N Frequency: _____
 Ear Infection Y/N Frequency: _____
 Pneumonia Y/N Frequency: _____
 Sinus infection Y/N Frequency: _____

Immunizations current for age: Y/N

Immunization card returned: Y/N

SPECIAL MEDICAL NEEDS:

Diabetes Y/N Age diagnosis: _____ Insulin dependent: Y/N Special diet: Y/N
 Bleeding disorders Y/N Age diagnosis: _____ Identify type: _____
 Cancer/leukemia Y/N Age diagnosis: _____ Identify type: _____
 Epilepsy/seizures Y/N Age diagnosis: _____ Identify type of seizure: _____
 Heart Condition Y/N Age diagnosis: _____ Identify type: _____

ALLERGIES: Identify what your child is allergic to:

Drugs _____ Asthma _____
 Animals _____ Insect Bite _____
 Foods _____ Others _____

Describe what happens to your child during an allergic reaction: **(Be Specific)**

Describe the treatment for the allergic reaction: **(Be Specific)**

COMPLETE THE FOLLOWING HEALTH CONCERNS:

Vision:

Does your child wear glasses/contacts _____ Y/N Date of eye exam: _____
Visual Problems: Squints Y/N Cross-Eyes Y/N Sensitive to bright light Y/N

Special accommodations in classroom:

Hearing:

Does your child have a hearing aid _____ Y/N Hearing loss Y/N
Cause of hearing loss: _____

Special accommodations in classroom:

Medications: Identify all taken

Name: _____ Dose: _____ Time: _____ Reason: _____

Ambulation:

Does your child use a: Wheelchair Y/N Crutches Y/N Walker Y/N Brace Y/N

Describe any physical problems or restriction for classroom, recess or physical education activities:

Describe other medical conditions or special care needs that your child has:

Please list/describe any other health concerns that the school should be aware of

IF YOUR CHILD HAS ANY SPECIAL MEDICAL NEEDS/ALLERGIES, PLEASE CALL THE SCHOOL NURSE AT 241-9700 extension 2309.

Roxie Kenitzer, RN-BSN
D.C. Everest District Nurse

Parent signature: _____

Date: _____