CENTRAL DAUPHIN SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
HEALTH HISTORY

TO PARENT(S) OR GUARDIAN:

The information requested on this form will be of help to the school nurse in determining the health status of your child in assisting him/her to receive maximum benefits from his/her educational opportunity. Please feel free to contact the nurse if you have any question to discuss, or information you wish to share. Certain information may be shared with other staff members when the certified school nurse deems it necessary for the health and safety of the student.

Student's Name_____ Grade____ Room____ Class Section ____

Address_____ Birthdate_____ Sex _____

Father's Name_____ Telephone _____
Last First Middle

Mother's Name _____
Last First Maiden

Name of Child's Physician or other source of medical care _____

Telephone_____

Student's Health History

A. Pregnancy and Birth

1. Did the mother take any medications or drugs (other than vitamins) during the pregnancy? Yes No
2. Was it a difficult birth? Yes No
3. What was the child's birth weight? _____
4. Did the child ever have any trouble as a newborn? Yes No

B. Early Childhood

1. Did the child have any special problems in the first six months? Yes No
2. At what age did the child sit alone without support? _____
3. At what age did the child walk alone without support? _____
4. At what age did the child begin to say two or three words together? _____
5. At what age did the child become completely toilet trained? _____

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C. General Health History

1. Has the child ever been in the hospital or had an operation? Yes No
   When? _____
   What for? _____
   _____
2. Has the child had any other illnesses, accidents, or broken bones? Yes No
   When ? _____
   What was the problem? _____
   _____
3. Is the child taking any medication? Yes No
   What for? _____
4. Has the child had any trouble with ears or hearing? Yes No
5. Has the child had any trouble with eyes or vision? Yes No
6. Has the child had more than six colds or throat infection; with a fever, a year? Yes No
7. Has the child ever had a convulsion or fit? Yes No
8. Has the child ever had a fainting spell? Yes No
9. Does the child complain of headaches? Yes No
10. Has a doctor ever said the child had a heart murmur? Yes No
11. Do any foods disagree with the child? Yes No
12. Does the child have any allergies or asthma? Please describe: Yes No
    _____
13. Does the child have any problem with passing water? (urination) Yes No
14. Has the child ever complained of pain or swelling in the arms or legs? Yes No
15. Has there ever been any trouble with the child's blood? Yes No
16. Does the child have trouble sleeping? Yes No
17. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:

Alcohol addiction	Diabetes	Mental retardation	Sickle cell trait
Allergy	Drug addiction	Nervous breakdown	Tuberculosis
Asthma	Heart Disease	Seizures	
Cancer	Lead poisoning	Sickle cell anemia	

Other _____

If your child has additional problems the school nurse should know about, please list them below:

_____
_____
_____

_____ _____
Date Signature of Parent or Guardian