Henry W Moore School
Student Health History

Date:_____

Please complete and return to the School Nurse to assist us in meeting your child's needs.

Student's Name: _____ Birth date: _____

Sex: M F Entering Grade: _____ Parent's names: _____

Primary Health Care Provider: _____

Dentist: _____

Please circle the appropriate number if any of the following conditions apply to your child and give a brief explanation in the space provided below. If needed, additional information may be given on the reverse side.

01 Allergy-Bee Sting (Requires medication)
02 Allergy-Food (Restrictions, Treatment?)
03 Allergy-Medication (list below)
04 Allergy-Pollen/Dust/Hayfever
05 Allergy-Unknown Cause
06 Anemia
07 Arthritis (Rheumatoid)
08 Asthma-Mild
09 Asthma-Requires Medication
10 Birth Defect (Chromosomal Disorder)
11 Blood Disorder
12 Blood/Blood Products (Religious Exclusion)
13 Bowel/Bladder Problems
14 Cancer/Leukemia
15 Cerebral Palsy
16 Color Blindness
17 Cystic Fibrosis
18 Diabetes
19 Eating Disorder/Under/Overweight
20 Endocrine Disorder
21 Epilepsy/Seizures
22 Eczema/Persistent rash
23 Growth Disorder
24 Heart Disease/Defect/Murmur
25 Hemophilia
26 Hyperactivity
27 Kidney Disease
28 Medication Prescribed
29 Menstrual Cramps (Severe)
30 Migraine Headaches
31 Muscular Dystrophy
32 Nosebleeds (Frequent)
33 Orthopedic/Bone/Muscle Problems
34 Physical Activity Limitation (Requires Physician's Note)
35 Rheumatic Fever History
36 Scoliosis
37 Sickle Cell Anemia
38 Speech Problem
39 Surgery
40 Tuberculosis
41 Other
42 No Known Health Problems

_____

_____

_____

Has your child had the chickenpox? Yes _____ No _____ If yes, please give date _____

OVER

Has your child had a professional eye exam? Yes _____ No _____ Date of last exam _____

Doctor's Name: _____

Does he/she wear glasses? _____ All the time?_____

Any other problems with vision? _____

Has your child had any hearing problems? _____

Has he/she had frequent ear infections? _____

Has he/she seen an ear specialist? _____

Name of specialist: _____ Address: _____

Ear tubes: Yes _____ No _____ Are they still in place? _____

Does your child take any regular medication, including over the counter medications? _____

Please list medications: _____

Parent/Guardian Signature _____ Date _____

Please use this area for additional comments or call the School Nurse at 483-2251, ext 128. Thank you.

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OVER