S-2

CITY OF MANCHESTER **(2-sided)**

Health Department - School Health Division

STUDENT HEALTH HISTORY
(To be completed by Parent/Guardian)

Name: (Full Legal) _____DOB: ____ /_____/_____ Gender: __M __F

Pregnancy & Birth

Did you have any health problems during your pregnancy?
____ Yes _____ No

Where there any complications with this child's birth or delivery? ____ Yes _____ No

What were the complications?

___ (Prematurity/Birth Weight _____)
___ Anoxia (baby didn't get enough oxygen)
___ Eclampsia/pre-eclamspia (mother's high blood pressure) / Toxemia (swelling)
___ Cesarean section
___ Respiratory distress syndrome
___ Meconium (baby's fecal matter excreted at or near birth)

Was this baby sick during the first 3 months of life?
____Yes ____ No

GENERAL HEALTH & HEALTH CARE

In general, would you say your child's health is?

___ Excellent ___ Very good ___ Good
___ Fair ___ Poor

Has a physician / health care provider ever told you that your child had any of the following?

___ Diabetes
___ Asthma
___ Congenital heart disease
___ Down syndrome
___ Cerebral palsy
___ Attention deficit hyperactivity disorder (ADD or ADHD)
___ Mental retardation
___ Learning disability
___ Developmental delays _____
___ Sickle cell anemia
___ Seizures

Is your child taking ANY medication? __ Y __ N
Name of medication(s) _____
_____

Has your child's behavior ever been assessed?
___ Yes ___ No ___ IEP ___ 504 Plan

_____
Parent/Guardian Signature Date

Eyes, Ears, Nose and Throat

___ Wears glasses
___ Three or more ear infections during the first 3 years of life
___ Tubes in his/her ears
___ Hearing loss/hearing aid
___ Strep throat two or more times in a year
___ Frequent nosebleeds

SKIN ALLERGIES

___ Problems with rashes
___ Allergies or reactions to medicines or injections
___ Allergy or reaction to bee sting or insect bites
___ Allergy to food / dyes

If yes, please explain: _____
Does your child have medication for it? __ Y __ N
Name of medication(s) _____

GASTROINTESTINAL

Does your child have any of the following?

___ Poor appetite
___ Excessive thirst
___ Frequent stomach aches
___ Frequent diarrhea
___ Trouble with constipation
___ Problem with kidneys
___ Problem with urine
___ Bladder or bowel control day or night

If yes, please explain _____

Other Problems and Illnesses

Has your child ever had any of the following?

___ Chicken pox. Date of disease _____
___ Serious accidents or injuries
___ Broken bones
___ A hospitalization overnight, other than birth
___ Special tests for health problems
___ Surgery

If yes, please explain: _____

Has your child lived in a house built before 1950 that had peeling paint? ___ Yes ___ No

___ Has your child ever been tested for lead poisoning?
___ Has your child ever been treated for lead poisoning?

_____
Reviewed by (School Nurse) Date

See Back of Page for Additional Questions

1. What is the primary language spoken at home?_____

2. Is English understood at home?_____

3. Has your child had previous schooling? No_____Yes_____Where?_____

4. When was the last time your child received a well-child check up? (that is, a general check-up when he/she was not sick or injured?)_____

5. Was there a time during the past year when your child needed health care but was unable to get it? Yes_____No_____

6. Child's Health Insurance:

    ____My child does not have health insurance

    ____Healthy Kids Gold/Medicaid

    ____Healthy Kids Silver

    ____Private Insurance

7. Does your child have a dentist? Yes_____:Name:_____
    No_____

8. How long has it been since your child was last seen by a dentist?

    ___My child has never seen a dentist

    ___More than 6 months but less than 1 year

    ___Six months or less