Hanover Area School District – Student Health History

Parents: Please fill out this form as completely as possible. Return to the school nurse to assist in completion of your child's

SCHOOL HEALTH RECORD

CHILD'S NAME: ______________________________ **DATE of BIRTH:** ____/____/_____ **Grade:** ________

PRIMARY ADDRESS: ____
 # STREET CITY STATE ZIP CODE

PRIMARY TELEPHONE: ____________________ **CELL PHONE:** ____________________ **WORK:** ______________

MOTHER/LEGAL GUARDIAN: ______________________________**RELATIONSHIP:** ________________

ADDRESS: ______________________________ **CELL PHONE #:** ____________________

EMAIL ADDRESS: ______________________________ **LIVES AT THE PRIMARY ADDRESS:** _____ **YES** ____**NO**

EMPLOYER: ______________________________ **WORK PHONE:** ____________________

WORK EMAIL: ______________________________

FATHER/LEGAL GUARDIAN: ______________________________**RELATIONSHIP:** ________________

ADDRESS: ______________________________ **CELL PHONE #:** ____________________

EMAIL ADDRESS: ______________________________ **LIVES AT THE PRIMARY ADDRESS:** _____ **YES** ____**NO**

EMPLOYER: ______________________________ **WORK PHONE:** ____________________

WORK EMAIL: ______________________________

PHYSICIAN NAME: ______________________________ **PHONE:** ____________________

HOSPITAL PREFERENCE: ____

DENTIST NAME: ______________________________**PHONE:** ____________________

CHILD'S HEALTH HISTORY

CHILD'S NAME: ____ **DATE OF BIRTH**: _____________

(please mark N/A if it does not apply to your child/family)

Please note any PRIOR:

Illness: ____

Injury: ____

Surgeries: ____

Hospitalizations: ____

Present medical/health conditions: (please check one box)

Asthma: ____**YES** ____**NO**

Diabetes: ____**YES** ____**NO**

Food Allergies ____**YES** ____**NO**

Seizures: ____**YES** ____**NO**

Heart Conditions ____**YES** ____**NO**

Other: ____**YES** ____**NO**

Please list other medical/health conditions:

____

Please list present medication or treatments (including Inhalers, Allergy Shots, Epipen, and or "As Needed Medications):

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

Does your child have a diagnosis of an allergy from a healthcare provider: ____**YES** ____**NO**

What is your child allergic to? ____

Are the allergies: ____ **Mild** ____**Moderate** ____**Severe**

Please list the symptoms of the allergy (ex. Hives, rash, runny nose, itchy eyes, wheezing, anaphylaxis)

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

List any adaptive equipment used by your child (glasses, contact, hearing aide, prosthetic devices, wheelchair, suctioning, tube feeding, catheter, etc.):

_________________________________ _________________________________

_________________________________ _________________________________

Is the child/family seeing a Therapist? ____ **YES** ____**NO** **Therapist Name:** __________________

FAMILY HEALTH HISTORY:

CHILD'S NAME: ____ DATE OF BIRTH: __________________

Does any member of the child's family have a chronic health condition (including addictions) that may cause your child to be concerned? ____ YES ______NO Please explain:

____

____

Have there been any changes in the family such as major illness, divorce, and/or deaths that may affect your child?

____ YES ____NO Please explain:

____

____

Do you have any concerns regarding your child, which you would to discuss with the school nurse?
____ YES ____NO Please explain:

____

____

If yes, please list the phone number(s) and best times for the school nurse to contact you. _______________

Can any of this information be shared with your child's teacher(s) and/or counselors? ____ YES ____NO

If yes, is there any of the information you do NOT want shared? ____ YES ____NO Please explain:

____

Signature of the Parent/Guardian: ____ Date: ____________________