CITY OF MERIDEN
DEPARTMENT OF HUMAN SERVICES – HEALTH DIVISION
SCHOOL HEALTH PROGRAM

HEALTH HISTORY FORM

Dear PARENT/GUARDIAN: Please complete the information below and return this form to the **SCHOOL NURSE** as soon as possible.

Student's Name _____ ☐ Male ☐ Female Date of Birth _____

Address _____ Telephone # _____

School _____ Grade _____ Student's Physician _____

Parent/Guardian's Name ***(please print)*** _____

Please check (✓) if your child has or has had any of the following:

		Date
Anemia	____	_____
Asthma	____	_____
Blood Disorder	____	_____
Cancer	____	_____
Chicken Pox	____	_____
Dental Braces	____	_____
Developmental Disorder	____	_____
Diabetes	____	_____
Ear Disorder	____	_____
Endocrine Disorder	____	_____
Eye Disorder	____	_____
Fainting Spells	____	_____
Fifth Disease	____	_____
Fractures	____	_____
Frequent Headaches	____	_____
Genetic Disorder	____	_____
German Measles	____	_____
Head Injury	____	_____
Heart Disease	____	_____
Hepatitis	____	_____
Hyperactivity	____	_____
High Blood Pressure	____	_____
Immune Deficiency	____	_____
Kidney Disorder	____	_____
Lead Poisoning	____	_____
Liver Disorder	____	_____
Lyme Disease	____	_____
Measles	____	_____
Meningitis	____	_____
Menstrual Disorder	____	_____
Mononucleosis	____	_____
Migraine Headaches	____	_____
Mumps	____	_____
Muscle/Bone/Spine Disorder	____	_____
Nosebleeds	____	_____
Physical Limitations	____	_____

		Date
Pneumonia	____	_____
Premature Birth	____	_____
Rheumatic Fever	____	_____
Scoliosis	____	_____
Seizures	____	_____
Sickle-Cell Trait/Disease	____	_____
Skin Disorder	____	_____
Strep Throat	____	_____
Tuberculosis	____	_____
Toileting Difficulties	____	_____
Other_____		_____

ADDITIONAL INFORMATION:

1. Is your child allergic to:
   ☐ Medications *specify*_____
   ☐ Foods *specify*_____
   ☐ Bee stings ___ Other _____
2. Is your child taking medication(s)?
   ☐ Yes *specify* _____ ☐ No
3. Does your child wear glasses or contact lenses?
   ☐ Yes ☐ No
4. Does your child wear a hearing aid?
   ☐ Yes ☐ No
5. Does your child use a wheelchair/walker or wear a leg brace? ☐ Yes ☐ No
6. Has your child been in the hospital? ☐ Yes ☐ No
   Reason _____ Date _____
7. Has your child had surgery? ☐ Yes ☐ No
   Type _____ Date _____
8. Does your child have health insurance?
   ☐ Yes ☐ No
9. Does your child see a dentist? ☐ Yes ☐ No

Parent/Guardian Signature _____ Date _____

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