Maine Regional School Unit #57
Nursing Services
Health History and Information
(to be completed by Parent/Guardian)

Dear Parent(s)/Guardian(s): **Grade**:_____ **School Year:**_____

Welcome to RSU #57. The health of your child is of concern to all of us since it greatly influences their ability to learn. Please complete **both sides of this form**. A school nurse will review this information and may contact you for questions or concerns. This information is confidential, will be kept in the health office by the school nurse, and will be shared only with school personnel on a need to know basis in order that the health care needs of your child will be safely met while at school. —Maine RSU#57 School Nurses

Childs Name:_____ **Date of Birth:**_____

Names of Parent/Guardian(s) **Relationship** **Daytime Phone Number**

_____
_____
_____

Physicians Name:_____ **Telephone**:_____
Date of last complete physical examination (approximate if known):_____

Has your child ever been diagnosed with Asthma by a Physician? Yes ◯ **No** ◯
If yes, when? _____
What could possibly trigger your child's asthma? _____
Please list **ANY** asthma medications and/or inhalers your child takes and when/how often it is taken:
_____

Does your child have a SERIOUS allergy to any of the following? If yes, please list the specific allergy and note if your child has required or will require emergency medication such as an Epi-Pen or Benadryl.
Food (be specific):_____ Medication:_____
Animal:_____ Stinging Insects/Bee Stings:_____
Other Allergies:_____

I**n the case of an emergency**, it is important for the school nurse to know what **medication(s)** your child takes at **HOME**. Please list any medication your child takes at home and at what time the medication is taken:_____

Please check any conditions your child has been under a doctor's care for and explain below:

☐ Anxiety	☐ Arthritis	☐ Attention Deficit (ADD/ADHD)	☐ Blood Disorder
☐ Cancer	☐ Cerebral Palsy	☐ Constipation	☐ Cystic Fibrosis
☐ Depression	☐ Diabetes	☐ Stomah or Intestinal Problems	☐ Hay Fever
☐ Headahces	☐ Head/Brain Injury	☐ Heart Condition	☐ Kidney Disease
☐ Lead Poisoning	☐ Lyme Disease	☐ Nosebleeds	☐ Seizure Disorder
☐ Skin Conditions	☐ Urinary Problems	☐ Other_____	

Explanations:_____
_____

Health History and Information
(to be completed by Parent/Guardian)

Has your child had any significant hospitalizations, accidents/injuries or surgeries? ◯Yes ◯No
If yes, please list these, when they happened, and give a brief explanation:_____
_____
_____

Does your child have any restrictions or require any assistive devices for Physical Activity?
If yes, please provide the School Nurse with a written statement from the physician specifying this information and give an explanation:_____
_____

Dental Information: Has your child had any dental injuries, caries, or problems? ◯Yes ◯No
If yes, please explain:_____
_____

Vision (please check any that apply to your child):
☐ Wears glasses: ◯Full time ◯Only for _____
Does your child appear to have any trouble seeing? ◯Yes ◯No
If yes, explain:_____
Has your child ever seen an eye doctor for vision concerns? ◯Yes ◯No
If yes, Doctor's Name:_____

Hearing (please check any that apply to your child):
☐ Has had a professional hearing evaluation
☐ Requires hearing aids or other devices
☐ Appears to have trouble hearing, explain _____
☐ Requires a special seating arrangement to help hearing, explain:_____
☐ Ear surgery and/or tubes put in ears: Date_____ Doctor's Name_____

Do you have any other health concerns pertaining to your child? ◯Yes ◯No
If yes, please explain:_____
_____

Parent/Guardian Signature:_____**Date:**_____

Nurse Notes:
_____
_____
_____
_____
_____

School Nurse reviewing this information:_____**Date:**_____