Cambridge School District
Health History

PLEASE PRINT

Child's Name (Last)_____ (First)_____ (MI)_____ Birthdate: _____
Address: _____ Primary Phone: _____
(Number, Street) (City) (Zip)
SCHOOL: Cambridge Elementary School_____ Nikolay Middle School_____ Cambridge High School GRADE:____
Primary Physician: _____ City:_____ PHONE:_____ FAX:_____
Dentist: _____ City:_____ PHONE:_____
Date of last dental exam: _____

Dear Parents and Students: In order to update our school health records and to become aware of any health concerns, we request that you complete this form. Additional information or comments are also welcome. Should your child have a medical concern during the school year, please notify the school. The school nurse is available for consultation or to receive referrals. She may be contacted through the school office phone numbers at extension 4104. The following screening programs will be conducted this year: Vision –4K, 5K, 1, 3, and 5; Hearing – 4 K, 5K, 1 and 3. Parents will be notified only if screening results indicate the student should be seen by a physician; other results are available on request.

Please indicate which of the following apply to your child. If you answer 'yes' to any item, please provide further explanation:

Y	N	Condition	Y	N	Condition
		Allergies:			**Hepatitis:**
		Seasonal:			**Birth Defects:**
		Reaction to insect bites:			**Orthopedic problems:**
		Animal:			**Emotional problems:**
		Food:			**Skin rashes:**
		Drug:			**Bedwetting:**
		Other:			**Hyperactive:**
		Asthma:			**Surgical Procedures:**
		Diabetes:			
		Epilepsy:			**Accidents:**
		Digestive Disorders:			**Injuries:**
		Heart Condition :			**Diseases or conditions which may affect their education:**
		Mental Health:			
		Hemophilia:			**Recent Immunizations:**

EYES				EARS			
Y	Year	**N**		**Y**	Year	**N**	
			Is or was cross-eyed				Frequent Infections
			Wears glasses				Any ear surgery
			Wear contacts				Has hearing loss
			Any vision loss				Has hearing aid (s)
			Any other eye problem				Any other ear problem
			Any eye surgery				Tubes in ears

Is your child taking medication? _____No _____YES, please explain:_____
Name of medication:_____ Taken during school hours? ____No ____Yes (**PLEASE COMPLETE A MEDICATION FORM)**

If there are any limitations on your child's activities at school, work, or otherwise, please list them and the reasons for the limitations below. If so, a dated note from the student's primary physician should state the reason, the amount of activity permitted, and the length of time this is to be in effect:

Please list any significant health problems of other family members: (Example: diabetes, cancer, heart disease, high blood pressure, scoliosis (curvature of the spine).

Pertinent updated health information for your child may be shared with the school he/she is attending. I give permission to have my child participate in the screening programs for vision and hearing.

_____ _____
Parent's signature Date this form completed