HEALTH HISTORY QUESTIONNAIRE - Branford Elementary Schools

Student Name:_____
(Last) (First) (Middle)
Grade Entering: _____ M _____ F_____ Date of Birth_____

Mother's Name: _____ Cell:_____

Mother's Address: _____ Email: _____

Father's Name: _____ Cell:_____

Father's Address: _____ Email: _____

Student's Pediatrician, Name & Phone:_____

_____

Student Previous School: _____ Contact #: _____

Is your child on any regular medications? No / Yes (if yes, please explain)

Does your child use other medications sometimes? No / Yes (if yes, please explain)

Is your child allergic to medicines? No / Yes (if yes, which medications?)

Does your child have Asthma? No / Yes Age of Diagnosis? _____
What causes your child's Asthma? _____

Medications used to treat Asthma? _____

Has your child ever had a nebulizer treatment? No / Yes (if yes, explain)
_____

Does your child suffer from environmental/seasonal allergies? No / Yes

Is your child allergic to any insect bites or stings? No / Yes (if yes, please explain)
_____

Does your child have any food allergies? No / Yes (if yes, please explain)
_____

Is your child prescribed any emergency medication for these allergies? No / Yes (if yes, what?)
_____

Miscellaneous Health Issues

Please check all that apply and explain in the space provided below.

Type I (Juvenile, Insulin Dependent)	Y N	Muscular Disorders	Y N
Diabetes Type II (latent, adult/metabolic syndrome)	Y N	Loss of Consciousness	Y N
Seizure/Epilepsy	Y N	Cancer/Leukemia	Y N
Febrile Seizures (with high temp)	Y N	HIV/AIDS	Y N
Frequent Headaches/Migraines	Y N	Hemophilia/Bleeding	Y N
History of Meningitis/Encephalitis	Y N	Frequent Urinary Infections	Y N
Tic disorder, Tremor, or Tourette's Syndrome	Y N	Bed Wetting	Y N
Stomach/Intestinal Difficulties/GERD	Y N	Growth Concerns	Y N
Constipation/Diarrhea	Y N	Anemia	Y N
Problems with Toilet Training	Y N	Weight Concerns - Over or Underweight	Y N
Skin Conditions/Eczema	Y N	Speech Therapy/Therapist	Y N
Vision Problems/Wears Glasses	Y N	Hearing Problems/PE Tubes	Y N
Other Medical Conditions NOT listed - please describe below.			

If you have answered YES to any of the above health issues, please give further details including the age of diagnosis, type of treatment, etc.

Your signature below indicates your permission to share the health information contained on this form, the assessment form and the cumulative health record with other school nurses, our school physician, and any teachers if it is so warranted for the health and safety of your child. In addition, the school nurse has permission to obtain further relevant information concerning your child's health from his/her physician or dentist.

Signature of Parent/Guardian ***Date***