BARRINGTON PUBLIC SCHOOLS
HEALTH HISTORY

Parent/Guardian– Please complete this form. The following information is needed for your child's school health record.

Student Name: _____ DOB: _____ M____ F____

Address: _____ Home Phone: _____ Grade: _____

Parent(s)/Guardian(s): _____

Physician Name: _____ Phone: _____

Last Physical Exam Date: _____Was child premature? Yes____ No ____ Birth Weight: _____

DISEASES/CONDITIONS							
	No	Yes	Date		No	Yes	Date
ADHD				Heart Condition			
Asthma				Hearing Problem			
Bleeding Disorder				Kidney Problem			
Bone injury/condition				Lead Poisoning			
Cancer				Lyme Disease			
Cystic Fibrosis				Nosebleeds			
Diabetes				Soiling/Wetting			
Ear Infections				Speech			
Eczema/skin condition				Tuberculosis			
Gastro-intestinal problem				Vision problem			
Headache/ Migraines				Other			

If yes, please explain: _____

_____

Does your child have ALLERGIES? Yes____ No____

If yes, please state the trigger below:

BEES/insects_____ Medication_____

FOOD_____ Other_____

Environment_____

Explain any allergic reaction: _____

Does your child require an **EpiPen?** Yes____ No____ **Benadryl**? Yes____ No____

Does your child require an **Inhaler**? Yes____ No____

Does your child take **any medication** on a regular basis? Yes____ No____

Please list medication(s), and dose: _____

_____

Reason for med: _____

Does your child have any seizure disorder? Yes____ No____

If yes, explain the type of seizure and the date of the last seizure: _____

_____

IF YOUR CHILD REQUIRES <u>ANY</u> MEDICATION TO BE ADMINISTERED AT SCHOOL, PLEASE NOTIFY THE SCHOOL NURSE FOR THE REQUIRED MEDICATION AUTHORIZATION CONSENT FORMS.

(Turn Form Over)

Has your child experienced the loss of a parent, sibling, or significant family member?

Explain: _____

Does your child have any emotional/behavioral problems?

If yes, please explain: _____

Has your child had any accidents, hospitalizations, or operations since birth? If yes, please explain and include the date if possible:_____

_____

Does your child require any of the following?

	No	Yes		No	Yes
Contacts			Hearing Aids		
Eyeglasses			Orthopedic Device		
Ear Tubes			Other		

Does your child require any medical procedures while at school? Yes____ No____

If yes, explain and contact the School Nurse: _____

Is your child restricted from physical activities? Yes____ No____

Explain: _____

Please include any comments you think might be helpful: _____

_____

IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF ANY CHANGES REGARDING YOUR CHILD'S HEALTH.

YOUR CHILD <u>MAY NOT ENTER SCHOOL</u> UNTIL <u>COMPLETE IMMUNIZATION INFORMATION AND PHYSICAL EXAM</u> ARE SUBMITTED AS REQUIRED BY STATE LAW.

PHYSICAL EXAMS MUST BE WITHIN THE PRECEDING 12 MONTHS OF ENTRY:

- **INTO THE DISTRICT**
- **PRIOR TO GRADE 7**
- **PRIOR TO KINDERGARTEN ENTRY (KINDERGARTEN ENTRANCE ALSO REQUIRES DOCUMENTATION OF LEAD SCREENING AND VISION TEST)**

Parent/Guardian Signature: _____ Date: _____

FOR THE HEALTH AND WELLBEING OF YOUR CHILD, NECESSARY HEALTH INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF.