Needham Public Schools
School Health Services
Health History

Student Name: _____ Age: _____ Birth Date: _____
Entering Grade: Select School: Select
Parent/Guardian Name: _____
Home Phone Number: _____Cell Phone Number: _____
Home Address: _____
Email Address: _____

Primary language of family:
☐ English ☐ Portuguese ☐ Spanish ☐ Russian ☐ Mandarin ☐ Other _____

PURPOSE: The Health History Form is a confidential document required for all students entering the Needham Public Schools. Please inform the school nurses of any changes in your child's health during the school year and contact the school nurse with any concerns or questions.

1. ALLERGIES
Does your child have diagnosed allergies? (check all that applies)

	Allergy	Prescribed an EpiPen?	Details about allergy:
Bees/Insects	No	No	_____
Foods	No	No	_____
Medications	No	No	_____
Latex	No	No	_____
Cold	No	No	_____
Other _____		Details: _____	

2. FAMILY HISTORY
Does anyone in your immediate family have a history of asthma, cancer, diabetes, seizures, heart problems, high blood pressure, tuberculosis (TB), color blindness, mental health issues, addiction, or other health conditions? Please describe:

3. GENERAL HEALTH AND DEVELOPMENTAL HISTORY
Does your child have a history of?

		If Yes, please explain
Hospitalizations/surgery	No	_____
Birth Defect	No	_____
Fainting episodes	No	_____
Convulsions/seizures	No	_____
Frequent headaches	No	_____

Diagnosed migraines	No	_____
Frequent nosebleeds	No	_____
Strep throat	No	_____
Asthma/wheezing	No	_____
Cystic Fibrosis	No	_____
Diabetes	No	_____
Skin rashes or condition	No	_____
Heart murmur	No	_____
Heart condition	No	_____
Sickle Cell Disease/trait	No	_____
Painful menstrual periods	No	_____
Orthopedic problems	No	_____
Difficulty sleeping	No	_____
Nightmares	No	_____
Unusual fears	No	_____
Aggressive behavior	No	_____
Tantrums	No	_____
Self-injurious behavior	No	_____
Dental problems	No	_____
Bleeding Disorder	No	_____
Other condition or syndrome	_____	Details: _____

Has your child ever been diagnosed with any of the following?

		If Yes, please explain
ADD/ADHD	No	_____
Autism/Asperger's Syndrome	No	_____
Developmental delays	No	_____
Pervasive Developmental Disorder (PDD)	No	_____
Anxiety	No	_____
Depression	No	_____
Eating Disorder	No	_____

4. EYES

Have you observed your child?

		If Yes, please explain
Crossing or turning eyes	No	_____
Squinting	No	_____
Complaining of double vision/blurry vision	No	_____
Needing to sit close to the television	No	_____

Has your child had?

Corrective lenses or glasses	No	_____
Eye surgery	No	_____
The need to patch an eye	No	_____
Date of last eye exam	_____	

5. EARS

Does your child

		If Yes, please explain
Fail to respond appropriately to directions/instructions	No	_____
Fail to respond when you call	No	_____
Require repetition of questions/ instruction	No	_____
Wear a hearing aid	No	_____

Has your child

Had a hearing test	No	_____
Been to a hearing specialist	No	_____
Been diagnosed with a hearing loss	No	_____
Had frequent ear infections	No	_____
Had placement of tubes in his/her ears	No	_____

Date of last hearing exam _____

BOWEL/BLADDER

Does your child have a history of?

		If Yes, please explain
Frequent stomach aches	No	_____
A poor appetite/eating difficulty	No	_____
Celiac Disease	No	_____
Encopresis	No	_____
Inflammatory Bowel Disease	No	_____
Irritable Bowel Syndrome	No	_____
Urinary tract infections	No	_____
Bedwetting	No	_____
Incontinence of stool	No	_____
Incontinence of urine	No	_____
Constipation	No	_____

Other _____ Details: _____

INJURIES

Has your child ever had?

		If Yes, please explain
Any serious accident or trauma	No	_____
Broken Bones	No	_____
A head injury/concussion	No	_____

8. *Is your child taking any medication, daily or as needed? Please list medications and explain reason for medication.*

9. *Describe any medical, mental health and/or life changes your student recently experienced.*

10. *Briefly describe your child (for example active, shy, strengths, weaknesses, etc).*
Please include any information that would be helpful for us to know when caring for your child.

11. *Do you or your child anticipate any challenges upon entering school?*

12. Is your child covered by health insurance? No
Would you like information about State health insurance? No

13. When was your child's last dental appointment? _____

14. What other assistance or information may we provide for you or your child?

Signature: _____ Date completed: _____
Name Printed: _____
Relationship to student: _____