

**Student Health History 2017/2018 – For New Students**

**Student Full Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Is your student covered by family medical/hospital insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, indicate carrier or plan name: \_\_\_\_\_ ID#: \_\_\_\_\_

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured students with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communication will remain confidential.

**Birth/ Developmental History**

Full Term (over 37 weeks) \_\_\_\_\_ Pre Term (# of weeks gestation) \_\_\_\_\_

Early Intervention  Yes  No

Did your student have any significant developmental delays (crawling, walking, talking)?  Yes  No

**Has your student had any- Please explain on the reverse side**

Operations  Yes  No Serious Accidents  Yes  No

Fractured Bones  Yes  No Serious Head Injury  Yes  No

Hospitalizations  Yes  No

**Please check all that apply:**

Allergies (additional information listed on Emergency Contact Information Sheet)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ADHD/ADD                 | <input type="checkbox"/> Cardiac Condition  | <input type="checkbox"/> Pervasive Development Disorder             |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Depression   | <input type="checkbox"/> Skin Problems                              |
| <input type="checkbox"/> Asthma/Wheezing          | <input type="checkbox"/> Diabetes Type I  | <input type="checkbox"/> Stomach/Bowel Problems                     |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Diabetes Type II   | <input type="checkbox"/> Scoliosis                                  |
| <input type="checkbox"/> Blood Disorder           | <input type="checkbox"/> Frequent Nose Bleeds   | <input type="checkbox"/> Seizure Disorder                           |
| <input type="checkbox"/> Bone or Joint Disease    | <input type="checkbox"/> Headaches <input type="checkbox"/> Chronic <input type="checkbox"/> Migraine | <input type="checkbox"/> Urinary Problems                           |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Weight Concerns (obesity, eating disorder) |

Vision (Explain) \_\_\_\_\_

Hearing (Explain) \_\_\_\_\_

Speech/Language (Explain) \_\_\_\_\_

Other Physical Conditions (Explain) \_\_\_\_\_

Other Behavioral/Emotional Conditions (Explain) \_\_\_\_\_

**Limitations or Restrictions**

List and explain any restrictions:

Dietary \_\_\_\_\_

Activity \_\_\_\_\_

Other \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

