

Student Health History 2019/2020 – 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: _____

