

# Wayland Public Schools

## Health History

Dear Parent or Guardian,

Please complete this form for your child so that we may have the information as part of your child's confidential health record. Please return it to your child's school, Attention School Nurse.

### PLEASE PRINT

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Birth Place: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_

If Guardian, so state: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Please list all other members of household:

Name:	Relationship	Date of Birth	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate if you child has had any of the following communicable diseases. If possible, state the year.

Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Poliomyelitis \_\_\_\_\_

Diphtheria \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Whooping Cough \_\_\_\_\_

German Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Other \_\_\_\_\_

Has your child ever had a serious accident or surgery? \_\_\_\_\_

If so, what? \_\_\_\_\_

Ever been hospitalized? \_\_\_\_\_

Why? \_\_\_\_\_

1. Has your child had any of the following conditions? If "yes," please give the details and year noted. If the child is being treated by a physician for any condition, please indicate.

Rheumatic Fever \_\_\_\_\_ More than 3-4 colds per year \_\_\_\_\_  
Kidney Disorder \_\_\_\_\_ Foot Disorder \_\_\_\_\_  
Fainting Spells \_\_\_\_\_ Thyroid Condition \_\_\_\_\_  
Heart Condition \_\_\_\_\_ Frequent Headaches \_\_\_\_\_  
Bone Condition \_\_\_\_\_ Nosebleeds \_\_\_\_\_  
Strep Throat \_\_\_\_\_ Epilepsy \_\_\_\_\_  
Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_  
Speech Problem \_\_\_\_\_  
Social Adjustment Problems \_\_\_\_\_ When: \_\_\_\_\_  
Any Other Serious Illness \_\_\_\_\_

2. Has your child ever been tested for tuberculosis? Yes \_\_\_\_\_ No \_\_\_\_\_  
Chest x-ray: When \_\_\_\_\_ Result \_\_\_\_\_  
Tine Test: When \_\_\_\_\_ Result \_\_\_\_\_  
Other Test: \_\_\_\_\_

3. Has your child had trouble with:  
Eyes crossing or turning in? \_\_\_\_\_  
Does your child go to an eye doctor? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Does your child wear glasses \_\_\_\_\_ Inflamed eyes or sties \_\_\_\_\_  
Have to hold things close to see \_\_\_\_\_

4. Has your child had any trouble with:  
Hearing \_\_\_\_\_ Ear Infections \_\_\_\_\_  
Does your child go to an ear doctor? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_

5. Does your child have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_  
To What: \_\_\_\_\_  
(food, insect bites, other)  
If food, does your child know what he/she should not eat? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Does your child take any medications regularly? \_\_\_\_\_  
Does he/she have to take any during school hours? \_\_\_\_\_  
What is the medication for? \_\_\_\_\_  
Name of medication \_\_\_\_\_

7. Is he/she under professional care for any condition? \_\_\_\_\_  
\_\_\_\_\_

8. Are there any family health conditions which create a problem for you? Yes \_\_\_\_\_ No \_\_\_\_\_  
What are they? \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ date

\_\_\_\_\_ signature of parent or guardian