School Health Service
Huntington Public Schools
Huntington, New York 11743

HEALTH HISTORY FORM

Student's Name_____ D.O.B./Place_____ Gender_____

Address_____ Phone_____ Physician's Name_____

School_____ Grade_____ Physician's Phone Number_____

Native language spoken in the home_____

Adults in Household (Name)	**Health Problems**
Mother_____	_____
Father_____	_____
Other_____	_____

Children in Household (Name)	**Age**	**School**	**Health Problems**
1. _____	____	_____	_____
2. _____	____	_____	_____
3. _____	____	_____	_____
4. _____	____	_____	_____

(Please list additional children on the reverse side of this form)

Please indicate if your child has any of the following:

	Year		Please Explain
Anemia	_____	Asthma/Allergies	_____
Chickenpox	_____	Diabetes	_____
Ear Conditions	_____	Frequent Nose Bleeds	_____
Nephritis	_____	Heart Disease/Cardiac Problems	_____
Urinary Problems	_____	Orthopedic Problems	_____
Rheumatic Fever	_____	Neurological Problems	_____
Tuberculosis	_____	Seizure Disorder/Epilepsy	_____
Contact with TB	_____	Skin Disorder	_____
Fifth Disease	_____	Frequent Colds/Sore Throat	_____

Is your child presently taking any medications? _____**Yes** _____**No**
If yes, please list the medical problem and medication: _____

To the best of your knowledge, please answer the following questions:

Does your child have visual problems? _____Yes _____No Explain _____
Does your child wear corrective lenses? _____Yes _____No
Is anyone in the family colorblind? _____Yes _____No. Who? _____
Is your child under treatment for a hearing loss? _____Yes _____No. If there are any special considerations, please explain _____
Are there any apparent speech problems? _____Yes _____No. Is child receiving speech therapy?
_____

Does your child have any known allergies? _____

(a) food allergies? _____

(b) lactose intolerance? _____

(c) latex allergies? _____

If there are any special considerations with the above, please explain:

_____

Was your child hospitalized at all since birth? _____Yes _____No**. If yes, state reason and date:**

_____

(a) Any operations? _____ reason and date _____

(b) Any serious illness or injuries? _____

Did the mother have any difficulties during her pregnancy, labor or delivery? _____Yes _____No. If yes, please explain _____

Did your child have difficulties at birth? _____Yes _____No

(a) Jaundice? _____

(b) Difficulty in breathing? _____ Explain _____

(c) Infections? _____Yes _____No. What type? _____

(d) Feeding Problems? _____Yes _____No. Explain _____

Was your child born with a Congenital Defect? _____Yes _____No. If yes, please describe:

_____

Was your child placed in a neonatal intensive care nursery or a high-risk nursery? _____Yes _____No

How long? _____

Was your child born prematurely? _____Yes _____No. How many weeks? _____

Was your child born post-maturely? _____Yes _____No. How many weeks? _____

Please list any restrictions/limitations of physical activities:

_____

Is there anything concerning the health of this child that school personnel should be aware of?

_____

_____

Additional Comments?

_____

_____

_____

Please list any additional children below:

Children in Household (Name)	**Age**	**School**	**Health Problems**
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Signature of Parent/Guardian_____ Date _____