

## MILLBROOK CENTRAL SCHOOL DISTRICT HEALTH HISTORY

Student name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 (Last, First, MI)

Parent/Guardian: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Siblings: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Check **YES** or **NO** to all items. Provide details on right for any items marked **YES**.

YES	NO	ALLERGIES	Details / Dates *List specific allergy and type of reaction
		Food allergy	
		Peanut allergy	
		Tree nut allergy	
		Medication allergy	
		Seasonal or environmental allergies	
		Allergy to bees, other stinging insects	
		History of sting allergy in family (specify)	
		Has child ever been stung ?	
		Does child have an Epi-Pen ?	
		Other allergies:	
YES	NO	Health Conditions	Details / Dates
		Asthma / Reactive airway	
		Does child use an inhaler and/or nebulizer?	
		Pneumonia or lung disorder	
		Heart murmur	
		Heart condition / high blood pressure	
		Bleeding disorder / Anemia	
		Diabetes            Date diagnosed: Insulin dependent: Yes / No	
		Diabetes in immediate family?	
		Seizure disorder Type:                    Medication:	
		Serious concussion or head injury	
		Recurrent headaches /migraines	
		Serious accident / injury	
		Surgery / Hospitalizations:	
		Fractures : specify	
		Joint or muscle disease / orthopedic problems	
		Scoliosis or abnormal spinal curve	
		Kidney or urinary problems	
		Bowel or digestive problem	
		Lactose intolerance	
		Gluten intolerance (celiac disease)	
		Skin condition	
		Lyme disease	
		Rheumatic fever	
		<b>CONTINUED ON BACK</b>	<b>CONTINUED ON BACK</b>

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Check **YES** or **NO** to all items. Provide details on right for any items marked **YES**.

YES	NO	Health Conditions	Details / Dates
		Mononucleosis (Mono)	
		Chicken pox (varicella)	
		Attention Deficit Disorder (ADD or ADHD) Date diagnosed: Current medication: Previous medication:	
		Autism / Asperger's	
		Neurological disorder	
		Behavioral or psychological disorder	
		Other:	
YES	NO	Specialists / Services	Details / Dates
		Speech/Language	
		Occupational Therapy	
		Physical Therapy	
		Neurologist	
		Psychology services	
		Allergist	
		Ear, Nose and Throat Specialist / Audiologist	
		Ophthalmologist / Optometrist	
YES	NO	Hearing and Vision	Details / Dates
		Frequent ear infections / fluid in ear	
		Hearing loss: ( Left / Right) Due to:                      Last evaluation:	
		Hearing aid	
		Vision problems/ eye defect: Date of last vision exam:	
		Wears glasses / contacts / both At all times:      Distance:      Reading:	
		Color deficiency	
		Other:	

List all medications your child takes on a daily or frequent basis: \_\_\_\_\_

\_\_\_\_\_

\*Are there any medications to be taken while school is in session? \_\_\_\_\_

*\*School medication policy, including physicians order, must be followed.*

List any health concerns not previously addressed: \_\_\_\_\_

\_\_\_\_\_

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