LUCERNE ELEMENTARY SCHOOL DISTRICT

Student Health History

Name:_____ Sex:_____ Birth date:_____

Address: _____ Telephone #:_____

Past Illness (Please check those which this child has had):

☐ Chickenpox	☐ Mumps	☐ Hepatitis	☐ Diabetes
☐ Diphtheria	☐ Strep Throat	☐ Pneumonia	☐ Epilepsy
☐ German Measles	☐ Kidney Disease	☐ Polio	☐ Convulsions
☐ Measles	☐ Whooping Cough	☐ Rheumatic Fever	☐ Meningitis
☐ Blood Disorders	☐ Heart Disease	☐ Muscle/Bone Disease	☐ Other

Comments regarding above:

_____

_____

Please list any other serious illness, operation, or injury and age when it occurred:

_____

_____

Has the child ever been around anyone known to have had tuberculosis? Yes: ☐ No: ☐

Has he/she had a skin test for tuberculosis? If yes, please give date: _____

Where was it done?: _____ Reaction: _____

When did this child last visit a private doctor? Date: _____ Dr.'s Name: _____

When did this child last visit a medical clinic? Date: _____

Medical Clinic Name: _____

Approximately how often does this child go to the above? _____

When did this child last visit a private dentist?: Date: _____ Dr.'s Name: _____

When did this child last visit a dental clinic?: Date: _____

Dental Clinic's Name: _____

Does your child wear glasses? Yes: ☐ No: ☐ If yes, Dr.'s Name: _____

Date of last eye examination: _____

Please check any of the following symptoms which have been noted recently:

☐ Four or more colds/year	☐ Dizziness	☐ Speech Difficulty
☐ Frequent sore throat	☐ Fainting Spells	☐ Running Ears
☐ Blurred vision	☐ Abdominal Pain	☐ Hard of Hearing
☐ Frequent headaches	☐ Frequent Urination	☐ Frequent Nosebleeds
☐ Frequent Sties	☐ Allergy	☐ Night Sweats
☐ Frequent pain in legs or joints	☐ Persistent Cough	☐ Tires Easily
☐ Hernia (rupture)	☐ Shortness of Breath	☐ Earaches

Is this child on any medication? Yes: ☐ No: ☐ If yes, what Medication?: _____

What dosage and frequency?: _____

Does he/she have any allergies? Yes: ☐ No: ☐ If yes, what kind?: _____

_____

Are there any problems or other matters which you would like to discuss with the school staff (teacher, nurse, other)?:

_____

_____

Date: _____ **Parent/Guardian Signature:** _____