

LUCERNE ELEMENTARY SCHOOL DISTRICT

Student Health History

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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

- |  |   |  |                                      |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Chickenpox      | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Strep Throat   | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Epilepsy    |
| <input type="checkbox"/> German Measles  | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio               | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Meningitis  |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Muscle/Bone Disease | <input type="checkbox"/> 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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Four or more colds/year         | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Speech Difficulty   |
| <input type="checkbox"/> Frequent sore throat            | <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Running Ears        |
| <input type="checkbox"/> Blurred vision                  | <input type="checkbox"/> Abdominal Pain      | <input type="checkbox"/> Hard of Hearing     |
| <input type="checkbox"/> Frequent headaches              | <input type="checkbox"/> Frequent Urination  | <input type="checkbox"/> Frequent Nosebleeds |
| <input type="checkbox"/> Frequent Sties                  | <input type="checkbox"/> Allergy             | <input type="checkbox"/> Night Sweats        |
| <input type="checkbox"/> Frequent pain in legs or joints | <input type="checkbox"/> Persistent Cough    | <input type="checkbox"/> Tires Easily        |
| <input type="checkbox"/> Hernia (rupture)                | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> 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: \_\_\_\_\_