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:** _____