

Holy Angels School
STUDENT HEALTH HISTORY UPDATE

Please complete and return to the school nurse by August 15th. This will assist in keeping an up-to-date Student Health Record on file. This information will be shared with staff and administration on a NEED TO KNOW basis unless you notify us otherwise.

NAME: _____ DATE: _____ SEX: M ___ F ___ GRADE: ___ DOB: _____

SCHOOL ATTENDED LAST YEAR: Holy Angels Other _____

1. Please check if your child has been diagnosed, has a history of, or has any difficulty with the following conditions. Give additional information under comments:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Measles | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures (Specify) | <input type="checkbox"/> Menstruation _____ | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Frequent Ear Infections | (date of onset) | <input type="checkbox"/> Surgery (Specify) |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision Difficulty |
| <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Hypertension (High BP) | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Infections | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> None of the listed conditions apply |
| | <input type="checkbox"/> Speech Difficulty | | |

COMMENTS: _____

2. Does your child have allergies to medicine, food, latex or insect bites? No Yes
Allergic to what: _____ What happens _____
Treatment: _____
3. Has your child had any illness since school ended last June? No Yes
Type of illness with date(s) _____
4. Has your child had surgery in the last 12 months? No Yes
Type of surgery with date(s) _____
5. Has your child received any immunizations in the last 12 months? No Yes
List immunizations with date(s) _____
6. Is your child being treated or evaluated for any health condition? No Yes
List condition(s) _____
7. Is your child on any medications or treatments? No Yes
Name of medication(s) or treatment(s) _____
Does your child need medication during school hours? No Yes
****IF YES, YOU MUST CONTACT THE SCHOOL NURSE AND MAKE THE NECESSARY ARRANGEMENTS**
8. Has your child ever been examined by an eye doctor? No Yes
Date of last exam _____ normal glasses/Contacts prescribed
When should your child wear his/her glasses/contacts? _____
9. Has your child had any emotional upsets (recent move, death, separation, divorce) in the last 12 months? No Yes
Please list: _____
10. Has your child had any injuries or fractures in the last 12 months? No Yes
Type of injury/fracture _____
List any limitations due to injury: _____
11. What was the date of your child's last dental exam? _____ Concerns: _____
Does your child have braces? No Yes
12. What was the date of your child's last physical examination? _____

*Thank you for helping to keep your child's School Health Record up to date.
If there are any changes during the school year, please inform the school nurse of these changes.*