SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
DEPARTMENT OF HEALTH SERVICES

HEALTH HISTORY FORM FOR STUDENTS

Student's name_____ School _____ Grade_____

Address_____ Home Phone_____

Date of Birth_____ Place of Birth_____ Sex M____ F_____

Mothers Name_____ Address_____ Phone_____
Mothers Place of Employment_____ Work Phone_____
Fathers Name_____ Address_____ Phone_____
Fathers Place of Employment_____ Work Phone_____
Physician_____ Dentist_____

Emergency: 1. Name_____ Phone_____
2. Name_____ Phone _____

Please check YES or NO for questions below so that our School Health Service may best serve your child.
Explain any yes answers in the space provided on the back of the form.

HAS YOUR CHILD EVER HAD:

SKIN	**yes**	**no**	**date**
Lesions	___	___	___
Rashes	___	___	___
EYE PROBLEMS			
Vision loss-Rt eye_____ Lt eye_____			
Amblyopia- Rt eye_____ Lt eye_____			
Glasses	___	___	___
Contact lenses	___	___	___
Hearing loss – Rt ear____ Lt ear____			
Ear tubes - Rt ear____ Lt ear____			
Infections	___	___	___
Frequent nose bleeds	___	___	___
Nose fracture/surgery	___	___	___
SORE THROAT			
Tonsillitis	___	___	___
Strep throat	___	___	___
Scarlet fever	___	___	___
Tonsils/adenoids removed	___	___	___
DENTAL PROBLEMS			
Braces	___	___	___
Capped teeth	___	___	___
Bridge/loss of teeth	___	___	___
CARDIOVASCULAR			
High Blood Pressure	___	___	___
Rheumatic fever	___	___	___
Heart Murmur	___	___	___
Heart Surgery	___	___	___
Cardiac Workup	___	___	___
LUNGS/RESPIRATORY			
Asthma	___	___	___
Allergies	___	___	___
Hives	___	___	___
Hayfever	___	___	___
Pneumonia	___	___	___
Bronchitis	___	___	___
Tuberculosis	___	___	___

GASTROINTESTINAL	**yes**	**no**	**date**
Jaundice	___	___	_____
Stomach Disorders	___	___	_____
Frequent Abdominal pain	___	___	_____
Ulcers	___	___	_____
MUSCULOSKELETAL	___	___	_____
Arthritis	___	___	_____
Joint pains	___	___	_____
Limb or back deformities	___	___	_____
Fracture (broken bone)	___	___	_____
Dislocation	___	___	_____
Scoliosis	___	___	____
Chronic sprains	___	___	_____
Recurrent injuries	___	___	_____
GENITOURINARY			
Hernia	___	___	_____
Bladder or kidney disorder	___	___	_____
Infections	___	___	_____
Testicles: injury/surgery	___	___	_____
Menstruation	___	___	_____
date began_____			
Problems_____			
NEUROLOGICAL			
Headaches	___	___	_____
Head injuries	___	___	_____
Concussions	___	___	_____
Convulsions	___	___	_____
Seizure Disorder	___	___	_____
Fainting/blackouts	___	___	_____
Paralysis/numbness	___	___	_____
Hyperactivity	___	___	_____
ENDOCRINE			
Diabetes	___	___	_____
Hypoglycemia	___	___	_____
Thyroid Condition	___	___	____
COMMUNICABLE DISEASES			
Measles	___	___	_____
Chicken Pox	___	___	_____
Mononucleosis	___	___	_____

HEMATOLOGY

Hepatitis A yes___ no___ date____ **Hepatitis B** yes___ no___ date___ **Hepatitis C** yes____ no____date____
Anemia yes___ no___ date____ Bleeding disorders yes___no___ date____ Transfusions yes___ no___date____
Sickle Cell Anemia yes___ no___ date____

PLEASE CONTINUE ON OTHER SIDE

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS TAKING AT HOME OR SCHOOL:
All medications have side effects and for your child's safety it is important for the School Nurse to have this information.

MEDICATION **DOSE** **TIMES**

_____

_____

_____

_____

_____

_____

HAS YOUR SON/ DAUGHTER:

Ever been a patient in a hospital?

Explain_____

_____

Had any operations? Explain_____

Had any accidents? Explain_____

Is your son/daughter under a physicians care now? _____

Is he/she allergic to any medication?_____

Has he/she had any psychological testing?_____

EXPLAIN YES ANSWERS HERE:

_____

_____

_____

_____

_____

COMMENTS:_____

_____

_____

PARENT OR GUARDIAN SIGNATURE

_____

DATE

Please contact the Health Office if you have any questions or if we may be of any service to you and your family.

_____ _____ _____

SCHOOL NURSE SCHOOL TELEPHONE