

ANTHONY WAYNE SCHOOLS  
HEALTH HISTORY

Date: \_\_\_\_\_

<b>Child's Full Name:</b> _____ <b>Date of Birth:</b> _____ <b>Gender:</b> _____				
	<small>Last</small>	<small>First</small>	<small>Middle Init.</small>	
<b>Parent Info:</b>	<b>Name</b>	<b>home phone</b>	<b>work phone</b>	<b>cell phone</b>
<b>Mother:</b>				
<b>Father:</b>				
<b>Guardian:</b>				

**I. Health Conditions:** Please check any of the following that your child currently has or has had in the past.

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| <input type="checkbox"/> <b>Abnormal Spine Curvature (Scoliosis, etc)</b><br><input type="checkbox"/> <b>ADD/ADHD</b><br><input type="checkbox"/> <b>Anemia</b><br><input type="checkbox"/> <b>Behavior Problems</b><br><input type="checkbox"/> <b>Birth/Congenital Malformations</b><br><input type="checkbox"/> <b>Cancer, Type _____</b><br><input type="checkbox"/> <b>Chickenpox, Date of the disease _____</b><br><input type="checkbox"/> <b>Chronic Diarrhea or Constipation</b><br><input type="checkbox"/> <b>Concern about relationship with siblings or friends</b><br><input type="checkbox"/> <b>Cystic Fibrosis</b><br><input type="checkbox"/> <b>Depression</b><br><input type="checkbox"/> <b>Diabetes Type I / Type 2 (Please contact your nurse at school)</b><br><input type="checkbox"/> <b>Difficulty sleeping</b><br><input type="checkbox"/> <b>Eczema/Psoriasis</b><br><input type="checkbox"/> <b>Emotional Disorders _____</b><br><input type="checkbox"/> <b>Frequent Headaches</b><br><input type="checkbox"/> <b>Frequent sore throat/infection</b><br><input type="checkbox"/> <b>Frequent stomach aches</b><br><input type="checkbox"/> <b>Heart disease/ type _____</b> | <input type="checkbox"/> <b>Kidney disease or abnormality</b><br><input type="checkbox"/> <b>Measles</b><br><input type="checkbox"/> <b>Meningitis or Encephalitis</b><br><input type="checkbox"/> <b>Menstrual Problems</b><br><input type="checkbox"/> <b>Migraine</b><br><input type="checkbox"/> <b>Nervous twitches/ tics</b><br><input type="checkbox"/> <b>Nutrition/Diet Problems</b><br><input type="checkbox"/> <b>Poisoning</b><br><input type="checkbox"/> <b>Seizure Disorder</b><br><input type="checkbox"/> <b>Sickle Cell Disease</b><br><input type="checkbox"/> <b>Skin condition</b><br><input type="checkbox"/> <b>Stool soiling</b><br><input type="checkbox"/> <b>Substance abuse (alcohol/drugs)</b><br><input type="checkbox"/> <b>Suicide Attempt</b><br><input type="checkbox"/> <b>Tendency to Faint</b><br><input type="checkbox"/> <b>Toothaches/ dental problems</b><br><input type="checkbox"/> <b>Urinary Tract Infections</b><br><input type="checkbox"/> <b>Urinary Accidents (night/day)</b><br><input type="checkbox"/> <b>Weight Problem</b><br><input type="checkbox"/> <b>Other chronic health problems</b> |
|--|--|

Explain checked items:

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**Physician's Name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**II. Allergies-** Please list allergy and describe reaction to:

Has medication allergy to:

1. \_\_\_\_\_ Reaction is: \_\_\_\_\_

2. \_\_\_\_\_ Reaction is: \_\_\_\_\_

Has food/seasonal/animal allergy to:

1. \_\_\_\_\_ Reaction is: \_\_\_\_\_

2. \_\_\_\_\_ Reaction is: \_\_\_\_\_

Recommended treatment if allergy is severe: \_\_\_\_\_

- III. Asthma/RAD-** 1. Has your child ever been diagnosed by a doctor as having asthma? \_\_\_\_\_
2. Has your child ever had episodes of wheezing (whistling in the chest) in the last 12 months? \_\_\_\_\_
3. In the last 12 months, have you heard your child wheeze or cough during or after active play? \_\_\_\_\_
4. Other than a cold, in the last 12 months, has your child had a dry cough at night? \_\_\_\_\_
5. In the last 12 months has your child been to a doctor, an emergency room, or a hospital for wheezing? \_\_\_\_\_

Daily medications for Asthma are: \_\_\_\_\_

As needed medications for Asthma are: \_\_\_\_\_

\* For more information on managing your child's asthma/RAD at school please contact the nurse in your building.

**IV. Medication Information** –Please list any medications that your child takes daily or frequently.

Name of Medication	What is the medication taken for?	How often and at what time is the medication taken?

**V. Illness/Injuries/Surgeries**-Please list any severe illnesses, injuries or surgeries:

Injury/Illness/Surgery:	Date(s)	Hospitalized:

**VI. Hearing-** Check all that apply.  
 \_\_\_\_\_Frequent Ear Infections (3 or more per year)  
 \_\_\_\_\_Hearing Loss (Circle one)- Rt. / Lft. / Both  
 \_\_\_\_\_Ear Tubes (Date placed\_\_\_\_\_)  
 Still in? Yes / No  
 Last Hearing Exam\_\_\_\_\_

**VII. Vision**  
 \_\_\_\_\_Vision Problems  
 \_\_\_\_\_Wears Glasses/Contacts (circle one)  
 Reason\_\_\_\_\_  
 Last Vision Exam\_\_\_\_\_

Please add any comments or concerns about your child's health, development, behavior, family or home life that you would like the school to be aware of:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

May we contact your child's physician for any further information or questions we may have regarding your child's health?      Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date