METRO NASHVILLE PUBLIC SCHOOL –METRO PUBLIC HEALTH DEPARTMENT
SCHOOL HEALTH PROGRAM

STUDENT HEALTH HISTORY

Dear Parent:

This Health History form will be used to identify and assist students with health problems. Participation is voluntary. Please return completed forms to the school to be provided to the school nurse.

Student's Name ____ **Sex** _______ **Birth Date** _________________
(Last) (First) (Middle)

Teacher / Homeroom name: ________________________________ **Grade Level:** __________________________

Address ____

Parent/Legal Guardian ____

Parent/Contact Number(s): _(_______)_______________________**or**__(________)_______________________

***Please provide contact numbers in case information on this form needs further verification/explanation. Thank you.**

1) Name of Provider________ ____ **Date of last check-up** __________________

Purpose of examination (check ✓ one): ______**Routine physical** ______ **Illness/Surgery**__________________________
(Specify)

2) Does your child have a health problem? (check ✓ where appropriate)

- ☐ My child has **no health problems** which would affect his/her school day.
- ☐ **Allergies to (Nuts, Bees, Food, Other** please list)____ ____________________What happens? ____ ____ Is epinephrine prescribed? Yes _____ No _____
- ☐ **Asthma,** is inhaler prescribed? Yes _____ No _____ Home only? _____ Need at school? _____ How often has it been used in the last year?___________________________ Date of last asthma episode? _______________________ Has your child gone to the hospital for asthma? Yes _____ No _____ When? _________ How long did they stay? ________
- ☐ **Diabetes** Type 1 _____ Type 2 _____ What medication taken? ______________________________
- ☐ **Seizures -** what type? ________________________________ Date of last seizure? ____________ Are any emergency rescue medications prescribed(Ex: Diastat; Nayzilam etc)? Yes _____ No_____ Home only? ____ Need at school? _____
- ☐ **Behavior/Emotional (ADHD, Depression)**
- ☐ **Catheterization**
- ☐ **Cancer/Leukemia**
- ☐ **Sickle Cell Anemia**
- ☐ **Heart Problems** Which problem?____ Date diagnosed? ______________

  Is it resolved now? Yes _____ No _____ What are the exercise restrictions your doctor has told you?______________________________
- ☐ **Any other condition you would like to tell us about**____

  ____

3) Does your child take medication? ____ **yes** ____ **no** **Name of medication(s):** ___________________________________

____

Time of day medication is given: ____

4) Has your child been in the hospital for any reason since birth? ____ **yes** ____**no** **If yes please explain:** ________________

____

5) Is there anything more about your child's health that you think is important for us to know? ________________________

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Parent's Signature____ **Date**__________________