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? ____________
  Is Diastat prescribed? 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? ________________________
____

______________________________________ ________________________
Parent's Signature **Date**