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**