Hardin County Schools
School Health Service
Health History

Dear Parent or Guardian:
We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to the nurse.

Pupil's Name________________________________ Sex______ Date of Birth____________
Last *First* *Middle*

School____ Grade______________________

Home Address____

Home Phone__________________________ Cell Phone__________________________
* IMPORTANT: If phone number changes please notify the nurse in case of Illness or Injury.

Father's Name _________________________ Mother's Name _________________________

- With whom does your child live?____
- When did your child have a physical examination?____________ ____________________
Date *Physician/Clinic*

Purpose of examination: Routine checkup ❑ Illness/Injury ❑ ________________________
Specify

- Does your child have a health problem? (Check where appropriate.)

Asthma_____ Diabetes_____ Vision_____ Sickle Cell Anemia_____ Injury_____

➢ Allergies: Dye_____ Environmental_____ Latex_____

Food___________________________ Insect stings____________________

❑ Nuts ❑ Shellfish ❑ Eggs ❑ Other Food______________________

Sinusitis________________________ Other________________________

Anemia_____ Hearing_____ Seizures/Convulsions_____ Heart_____

Does your child have an EpiPen? ____________

Explain:____

____

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(over)

- Does your child take medication? ________ Name of medication(s) ____________________________

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- Has your child been hospitalized for any reason since birth?____________________________________

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- Does any close relative in your family have a history of: (Check and indicate relationship to this child.)

  Diabetes ________ Cancer ________ High Blood Pressure ________

  Birth Defect ________ Anemia ________ Epilepsy ________

  Sickle Cell Anemia ________ Heart Disease ________ Learning Problems ________

  Mental Retardation ________ ADD/ADHD ________

  Other____

- Are there any problems in the home that might affect your child's learning?______________________

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- Is there anything more about the child's health that you think is important for us to know? ____________

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____ ________________________________

Parent's Signature Date