

**ARLINGTON PUBLIC SCHOOLS
HEALTH SERVICES**

HEALTH HISTORY

Parents/Guardian:

The following information is requested for the School Nurse in understanding and helping to safeguard your child's health.

Please complete this questionnaire and return it to your child's School Nurse.

STUDENT'S NAME _____

Date of Birth _____ **School** _____

HEALTH STATUS: Please answer yes or no if your child has or had any of the following:

1. **ALLERGIES:** _____

2. **ASTHMA:** _____

3. **BEDWETTING:** _____

4. **BOWEL PROBLEMS:** _____

5. **DIABETES:** _____

6. **EAR INFECTIONS:** _____

7. **ENLARGED/INFECTED TONSILS:** _____

8. **FREQUENT URINATION:** _____

9. **HEADACHES:** _____

10. **HEARING PROBLEMS:** _____

11. **HEART CONDITION:** _____

12. **SEIZURES:** _____

13. **TEMPERATURE OF 103 or above:** _____

14. **VISION PROBLEMS:** _____

GLASSES: _____

15. **OTHER ILLNESS/ACCIDENTS:** _____

16. **COMMENTS:** _____

a. Does your child receive regular physical

checkups? _____ Doctor: _____

b. Has your child ever been on prolonged medication _____ Name of

medication: _____

c. Is your child on medication now? _____ Name: _____

d. Has your child ever been hospitalized? _____

Reason: _____

e. Are you concerned about any phase of your child's physical, social or Behavioral development? _____

Parent's
Signature _____ **Phone#** _____ **Date** _____