Note: *this form provides information about your child's health history and health care. This information is confidential and will be maintained in the student's school health record. If you do not understand a question or word, please ask for assistance.*

Plymouth Public Schools
Student Health History

Date: _____

First Name:	Middle Name:	Last Name:

Date of Birth:	Place of Birth:	Date of Last Physical: Date of Last Dental Exam:	Primary Language:

Section One: Student Medical History

Does your child have a history of: *(Select Yes or No)*

Diagnosis	Yes	No		Yes	No	Diagnosis:	Yes	No
Allergies	☐	☐	Headaches/Migraines	☐	☐	Tobacco Use	☐	☐
Autism Spectrum Disorder	☐	☐	Respiratory Disorders /Asthma	☐	☐	Attention Deficit/ Hyperactivity Disorder	☐	☐
Other Conditions: Physical/Developmental								
Current Medications/ Dose:								

Section Two: Student Medical History *(Select all that apply)*

1. Does your child have a life threatening allergy? ☐ YES ☐ NO
   a. Allergens: _____
   b. Does your child require an Epipen®? ☐ YES ☐ NO
   c. Allergist/Phone: _____ / _____
2. Does your child:
   a. have asthma? ☐ YES ☐ NO
   b. use a maintenance inhaler? ☐ YES ☐ NO
   c. use a rescue inhaler? ☐ YES ☐ NO
3. Does your child have Cancer/Leukemia? ☐ YES ☐ NO
   a. Current Status: _____ ☐ Under treatment ☐ In Remission
   b. Date of Diagnosis: _____ Last Treatment Date: _____
   c. Oncologist/Phone: _____ / _____
4. Has your child ever had a concussion? ☐ YES ☐ NO
   a. Date of Injury: _____
   b. Was your child seen by a physician? ☐ YES ☐ NO
   c. Was your child cleared to return to school/play/sports? ☐ YES ☐ NO
   d. Residual restrictions: _____
5. Does your child have:
   a. Insulin Dependent Diabetes? ☐ YES ☐ NO
   b. Use an: ☐ Insulin pump ☐ Pen ☐ Inject via syringe ☐ Continuous Glucose Monitor
   c. What type of insulin does your child use? ☐Lantus ☐Novolog ☐Humalog ☐Other: _____
   d. Endocrinologist/Phone: _____ / _____
   e. Date/Result of last A1C level: _____ / _____
6. Has your child had any recent fractures? ☐ YES ☐ NO
   a. Date/site of injury: _____ / _____
   b. Any related restrictions: _____
7. Does your child have seizure disorder? ☐ YES ☐ NO
   a. Date of last seizure: _____
   b. Medications: _____
   c. Neurologist/Phone: _____ / _____

Continue on page two

Note: *this form provides information about your child's health history and health care. This information is confidential and will be maintained in the student's school health record. If you do not understand a question or word, please ask for assistance.*

Student Name:_____ **Student Health History** (Page 2)

Section Three: Student Surgical History *(Complete as appropriate)*

Diagnosis	Date	Diagnosis	Date	Diagnosis	Date
Appendectomy		Ear Tubes		Heart Surgery	
Tonsillectomy & Adenoidectomy		Adenoidectomy with PE tubes		Other:	

Section Four: Student Mental/Behavioral Health/Emotional Concerns *(Complete as appropriate)*

It is well documented that there is a connection between a child's living environment, mental/emotional health, physical health and ability to succeed academically. Answering the following questions will help the school nurse advocate for your child's day-to-day needs.

Diagnosis	Yes	No	Hospitalizations Dates	Medications	Case Workers/Counsellor
Alcohol Abuse	☐	☐			
Anxiety	☐	☐			
Depression	☐	☐			
Drug Abuse	☐	☐			
Mood Disorder	☐	☐			
Oppositional Defiant Disorder	☐	☐			
Post-Traumatic Stress Disorder	☐	☐			
School Phobia	☐	☐			
Other:	☐	☐			

- Do you have any questions or concerns regarding your child's emotional and/or physical health issues that you would like to discuss in private with your school nurse? ☐ Yes ☐ No
- How should the nurse contact you to arrange a discussion? _____

Section Five: Family Health Concerns *(Complete as appropriate)*

Relationship	Alcohol Abuse	Asthma	Autism Spectrum Disorder	Cancer	Diabetes	Domestic Violence	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Learning Disability	Thyroid Disease
Mother															
Father															
Sister															
Brother															
Other															
Other															

Student's Siblings			
Name	Birth Date	Name	Birth Date

Passive Smoke: Student Exposure to People Who Smoke *(Circle all that apply)*	
Tobacco: ☐ Never ☐ Yes ☐ In the Past	Packs/day *(circle one)*: ½ 1 2 3 or more
Years of Use: ☐ Less than 1 year ☐ 1-5yrs ☐ 5-10yrs ☐ Greater than 10 yrs.	If you answered yes: ☐ Smokes Inside ☐ Smokes outside only
Smokeless Tobacco (Chewing, *E*cigarettes): ☐ Never ☐ Yes ☐ In the Past	Does the individual still use tobacco products? ☐ Yes ☐ No

_____ _____

Parent/Guardian *(please print)* Parent/Guardian Signature

Phone: _____ Date: _____