

**Mohonasen Central School District**  
**Health History for Elementary Students**

**Student Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Sex** \_\_\_ **Gr.**\_\_\_

*Please date and explain any of the following illness/conditions which have affected your child.*

*Please write **NO** if it does not apply:*

Birth history: Full Term \_\_\_ Premie \_\_\_ Birth weight \_\_\_\_\_ Condition at birth \_\_\_\_\_

Whooping Cough \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Mononucleosis \_\_\_ Pneumonia \_\_\_ Chicken Pox \_\_\_ Fifths Disease \_\_\_ Hepatitis \_\_\_ Measles \_\_\_

Strep Throat {last occurrence} \_\_\_\_\_ Frequency \_\_\_\_\_

**Asthma** \_\_\_\_\_ **Triggers** \_\_\_\_\_ **Controlled with** \_\_\_\_\_

Allergies \_\_\_\_\_ To what \_\_\_\_\_ Controlled with \_\_\_\_\_

**Insect bite sensitivity** to: \_\_\_\_\_ Treatment \_\_\_\_\_

Diabetes \_\_\_\_\_ Controlled with \_\_\_\_\_ Self administered? \_\_\_\_\_

Heart defect or condition \_\_\_\_\_ Treatment \_\_\_\_\_

Seizures [date of last one and type] \_\_\_\_\_ Controlled with \_\_\_\_\_

Kidney/Bowel problems \_\_\_\_\_ Toileting issues \_\_\_\_\_

Neurologic Condition \_\_\_\_\_ Autism \_\_\_\_\_ Cerebral Palsy \_\_\_\_\_

Has your child been diagnosed with **ADD or ADHD**? \_\_\_ Date \_\_\_\_\_ Doctor \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

*Behavior or emotional Problems* \_\_\_\_\_ *Learning Disabilities* \_\_\_\_\_

Ear Infection ~ Frequency \_\_\_\_\_ Tubes/date \_\_\_\_\_ Hearing Loss \_\_\_\_\_ H.Aids \_\_\_\_\_

Speech Issues \_\_\_\_\_ Therapy \_\_\_\_\_

Vision: Normal \_\_\_ Wears Glasses \_\_\_\_\_ For \_\_\_\_\_ When \_\_\_\_\_

**Orthopedic problem** \_\_\_\_\_ **correction** \_\_\_\_\_

Uses: braces \_\_\_ Crutches \_\_\_ Cane \_\_\_ Walker \_\_\_ Wheelchair \_\_\_\_\_

Occupational Therapy \_\_\_ for \_\_\_\_\_ Physical Therapy \_\_\_ for \_\_\_\_\_

**Surgery** \_\_\_\_\_ Type and Date \_\_\_\_\_

**Medications** student is currently on \_\_\_\_\_ for \_\_\_\_\_

Is there a need to take the medication in school? Yes \_\_\_ No \_\_\_

Dental problems/appliances \_\_\_\_\_

Last school attended \_\_\_\_\_ Phone \_\_\_\_\_

**Please state below anything else the school nurse should be made aware of:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pediatrician's name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Dentist** \_\_\_\_\_ **Phone** \_\_\_\_\_

*Parent/Guardian signature* \_\_\_\_\_ *Date* \_\_\_\_\_