

**WINDHAM SCHOOL DISTRICT
Windham, NH 03087**

OFFICE OF THE SCHOOL NURSE

HEALTH HISTORY

Print Student's Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work/Mobile Phone: _____

Email: _____

ALLERGIES (food, insect sting, medications, etc.): _____

Does your child have an Epi-Pen? Y _____ N _____

Previous illnesses: _____

Previous surgeries: _____

Vision problems: _____

Has your child had a vision screening within the past year at a doctor's office? Y _____ N _____

Hearing problems: _____

Has your child had a hearing screening within the past year at a doctor's office? Y _____ N _____

History of ear infection	Y _____	N _____
Tubes	Y _____	N _____
Asthma/inhaler	Y _____	N _____
Heart disease	Y _____	N _____
Kidney infection	Y _____	N _____
Diabetes	Y _____	N _____
Tuberculosis	Y _____	N _____
Seizures	Y _____	N _____

Skin conditions (hives, eczema): _____

Physical handicap: _____

Orthopedic problems/restrictions: _____

Was pre-natal period and birth considered normal? Y _____ N _____

If no, please explain: _____

****Please submit a copy of a physical exam, done within the past year to the health office.***

Parent signature

Date