NORWOOD PUBLIC SCHOOLS

HEALTH HISTORY

Name of Student_____

Grade_____ Date of Birth_____ Place of Birth _____

Does your child have any of the following:

_____Allergies
_____Asthma, Wheezing
_____Diabetes
_____Seizure Disorder
Last Seizure_____
_____Heart Condition
_____Hearing Problems
_____Vision Problems
_____Dental Problems
_____Bone/Joint Problems
_____Stomach/GI disorders
_____Bleeding disorders
_____Chronic/Migraine headaches
_____Premature Birth
Weeks of Gestation_____
_____Other Chronic Illness
_____Other significant history including medical, behavioral or mental health issues

Please give details of the above conditions:

_____
_____
_____
_____

Has your child had any of the following:

_____Serious Accidents
_____Operations
_____Fractured Bones
_____Serious Head Injury
_____Hospitalization

Please give details of the above conditions:

_____
_____
_____
_____

Is your child toilet trained? ___Yes ___No

Does your child use any of the following aids:

Contact lenses, eye glasses, hearing aid, ear tubes, crutches, braces for arm, leg, or back, dental appliance, wheelchair

Please Specify_____

_____

Other_____

_____

Has your child ever had an allergic reaction to an insect bite, food, medication?

Which_____
When_____
What happened?_____
_____
_____
_____

Is your child taking any daily medication?

Name of Medication_____
For what purpose_____

Is you child taking any medication on an as needed basis?

Name of Medication_____
For what purpose_____

Can your child participate in all school activities?

If "NO" please explain_____
_____
_____

May we share the above information with school staff?

_____Yes _____No

Please call the school nurse with any questions or to discuss any of the above information.

Health Insurance Provider_____

Physician's Name_____

Dentist's Name_____

_____
Signature of Parent/Guardian

_____
Date