Rochester School Health Services
Health History
(To Be Completed By Parent)

Student's Name _____ Date of Birth _____/_____/_____ Sex _____
Doctor's Name _____ Phone: _____

My child's health information may be shared with those people who work with my child if it affects their medical care or education. If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

Does your child have any allergies? _____ If yes, explain to what, how they react and how it is treated. _____
_____
_____

Does your child have now (or in the past) any ear/hearing problems? _____ If yes, explain._____
_____
_____

Has your child had Chicken Pox? ___ **If Yes,** give age, date/year, **or Lab Test results (required for grds K-9)**
_____

Is your child on any medications? _____ If yes, give the name of medication, when taken & reason:
_____
_____
_____

Is your child presently under medical care? _____ If yes, explain: _____
_____
_____

Has your child experienced any emotional trauma? ____ If yes, explain. _____
_____
_____

Is there any reason your child cannot participate in a full program of activities at school?_____ If yes, explain _____
_____
_____

Please check any of the following your child has/had:

_____RAD (Reactive Airway Disease)	_____Asthma	_____ ADD/ADHD
_____Orthopedic Problems	_____Seizure Disorder/convulsions	_____Behavioral Issues
_____Serious Illness/Injuries	_____Diabetes	_____Skin Disorder
_____Heart Disease	_____Surgery (operations)	_____Nutritional Concerns
_____Hospitalizations		

Please give us more information about any of the items you have checked above: _____
_____
_____

Are there any other concerns or chronic health conditions you would like to mention? _____
_____
_____

Health history completed by: _____ Date completed _____/_____/_____