

**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-11)**  
\_\_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_