WACONIA PUBLIC SCHOOLS • EXPLORE YOUR PASSIONS. CREATE YOUR SUCCESS.

STUDENT HEALTH HISTORY

Please complete the information below and return to Health Services

Student Name:_____ **Birthdate:**_____ **Grade:**_____

Parent /Guardian: _____

School: ☐ Bayview ☐ Middle School ☐ Laketown ☐ High School ☐ Southview ☐ WLC

Medical Diagnosis(es): _____

1. Is the student well most of the time? ( ) Yes ( ) No
2. Does the student have frequent sore throats with fever? ( ) Yes ( ) No
3. Does the student frequently have headaches, stomachaches, or other pain? ( ) Yes ( ) No
   Type:_____
4. Does the student have any lumps, or sores that are not healing? ( ) Yes ( ) No
5. Has the student ever been hospitalized? If yes, for what and when? ( ) Yes ( ) No
   _____
6. Has the student ever had any serious accidents, or poison ingestions?_____ ( ) Yes ( ) No
7. Has the student gone to the doctor in the last year? ( ) Yes ( ) No
   When & Why? _____
8. Is the student taking medications now? ( ) Yes ( ) No
   Medications:_____
   Reason: _____
9. When did the student last go to the dentist? (If over six months, check "No") ( ) Yes ( ) No
   Date: _____
10. Was dental work completed?_____ ( ) Yes ( ) No
11. Are you or the student concerned about his/her height or weight? _____ ( ) Yes ( ) No
12. Are you or the student concerned about his/her appetite or eating pattern?_____ ( ) Yes ( ) No
13. Are you or the student concerned about his/her body development?_____ ( ) Yes ( ) No
14. Do you or the student have questions about smoking, drinking, or use of drugs? ( ) Yes ( ) No
15. Does the student have any physical restrictions? If yes, what? ( ) Yes ( ) No
    _____
16. Has the student ever gone to a medical specialist? If yes, who?_____ ( ) Yes ( ) No
    When?_____ Why?_____
17. Does the student have any handicaps, illnesses, or diseases? ( ) Yes ( ) No
    Explain:_____

(Over)

PAST HISTORY (check any of the following that the student has ever had)

( ) "Red" or "Hard" measles
( ) German or 3-Day measles
( ) Mumps
( ) Chickenpox – Date:_____
( ) Meningitis
( ) Scarlet Fever
( ) Rheumatic Fever
( ) Arthritis
( ) Pneumonia
( ) Cancer
( ) Convulsions, Seizures
( ) High fever (above 104 for 3 days)
( ) Vaginal/Pelvic infections
( ) Hepatitis
( ) Premature Birth
( ) Trouble breathing at birth
( ) Birth injury or defect
( ) Head injury
( ) Allergies:
___ Eczema ___Hives
___ Hayfever ___ Wheezing or Asthma
___ Drug/medication: _____
___ Food intolerance: _____
( ) Heart trouble/High Blood Pressure
( ) Diabetes
( ) Kidney or Bladder Infection

*Additional Information:*_____

RECENT HISTORY (check any of the following that apply to the student)

( ) Frequent Urination
( ) Burning or painful urination
( ) Bowel Problems
( ) Shortness of Breath
( ) Swollen Glands
( ) Tires Easily
( ) Dizziness, Fainting Spells
( ) Bleeds Easily
( ) Persistent Cough
( ) Difficulty Seeing
( ) Difficulty Hearing
( ) Joint Pain
( ) Skin Problems
( ) Sleep Problems
( ) Depression
( ) Weight Loss
( ) Persistent Vomiting
( ) Chest Pain

*Additional Information:*_____

Are there any physical concerns that the physical education teacher should be aware of ?_____
_____

Note: if your child has a condition that prevents them from participating in physical education, a note from your physician will be required.

Any concerns related to hearing and vision?_____
_____

Any pregnancy/labor or delivery issues, please describe:_____
_____

Does student have medical insurance? ( )No ( )Yes, provider/company name: _____
If no, would you be interested in resources ( )No ( )Yes

Please list any special concerns:_____
_____
_____

_____ _____
Signature of Parent/Guardian completing this form Date

Box to be completed by Health Services Staff:

_____IEP _____Initial
_____Reassessment
_____504
_____Individual _____Kindergarten
_____Transfer

Nursing Notes:_____
_____
_____
_____
_____