Shalom School

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STUDENT HEALTH HISTORY FORM

TO BE COMPLETED AND SIGNED BY PHYSICIAN

GENERAL INFORMATION

Student's name: _____ Birthdate: _____ ☐ Boy ☐ Girl

Date of most recent physical examination: _____Weight: _____ Height: _____

Student has been screened for: ☐ Vision ☐ Hearing Date of screening: _____

The student is undergoing medical treatment at this time: ☐ Yes ☐ No

If yes, please describe the conditions and treatment:

_____

_____

MEDICATION

Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins, over the counter products, and natural remedies.

IF YOUR CHILD WILL BE TAKING ANY MEDICATIONS WHILE AT SCHOOL ON A REGULAR OR AS-NEEDED BASIS PLEASE COMPLETE THE PARENT/PHYSICIAN MEDICATION CONSENT FORM AND RETURN IT TO THE SHALOM SCHOOL OFFICE SIGNED BY A PHYSICIAN.

IMMUNIZATION RECORD - PLEASE COMPLETE AND/OR ATTACH A COPY OF CHILD'S CURRENT IMMUNIZATION RECORDS.

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

ALLERGIES - PLEASE ATTACH ANY RELEVANT ALLERGY PLAN. ☐ Student has no known allergies

Student is allergic to: ☐ Food ☐ Medicine ☐Environment (insect stings, hay fever, etc.) ☐Other

Please describe what the student is allergic to and the typical reaction:

_____

_____

HEALTH HISTORY Please mark "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the child:

Ever been hospitalized?	☐ YES ☐ NO
Ever had surgery?	☐ YES ☐ NO
Have a recurrent/chronic illness?	☐ YES ☐ NO
Had a recent infectious disease?	☐ YES ☐ NO
Have diabetes?	☐ YES ☐ NO
Had a recent injury?	☐ YES ☐ NO
Have any skin problems?	☐ YES ☐ NO
Had seizures?	☐ YES ☐ NO
Had headaches?	☐ YES ☐ NO
Had asthma/wheezing/shortness of breath?	☐ YES ☐ NO
Passed out/had chest pain during exercise?	☐ YES ☐ NO
Traveled outside the US in the past 9 months?	☐ YES ☐ NO
Had fainting or dizziness?	☐ YES ☐ NO
Ever had back/joint problems?	☐ YES ☐ NO
Have a history of bedwetting?	☐ YES ☐ NO
Have problems with diarrhea/constipation?	☐ YES ☐ NO
Have problems falling asleep/ sleepwalking?	☐ YES ☐ NO
Born prematurely?	☐ YES ☐ NO
Wear glasses, contacts, or protective eyewear?	☐ YES ☐ NO
Had a significant life event that continues to affect the child's life? (history of abuse, death of loved one, family change, etc.)?	☐ YES ☐ NO
During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ YES ☐ NO
Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ YES ☐ NO
Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ YES ☐ NO

Please explain any "Yes" answers in the space below.

_____

_____

HEALTH PRACTITIONER SIGNATURE:

_____ _____ _____

Name (Please Print) Signature Date

PARENT/LEGAL GUARDIAN SIGNATURE:

_____ _____ _____

Name (Please Print) Signature Date