בית ספר שלום • 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:

____

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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:

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____
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HEALTH HISTORY

Please circle "Yes" or "No" for each statement. Explain "Yes" answers below. Has/does the child:

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

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

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HEALTH PRACTITIONER SIGNATURE:

______________________________ ________________________________ _____________
Name (Please Print) Signature Date

PARENT/LEGAL GUARDIAN SIGNATURE:

______________________________ ________________________________ _____________
Name (Please Print) Signature Date