

## Peters Township School District

### Health History for School Nurse

TO HELP US GET TO KNOW YOUR CHILD BETTER AND PROVIDE NECESSARY CARE, PLEASE COMPLETE THE FOLLOWING:

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

☐ Asthma

Medication: \_\_\_\_\_

☐ Head Injury/Concussion

☐ Allergies:

Food: \_\_\_\_\_

Medication: \_\_\_\_\_

Bee/Insect: \_\_\_\_\_

Other: \_\_\_\_\_

Does your child have an Epi-Pen? ☐ Yes ☐ No

☐ Hearing Defect

☐ Heart Disease

Congenital Defect: \_\_\_\_\_

Murmur: \_\_\_\_\_

Activity Restriction? ☐ Yes ☐ No

☐ Congenital Condition

Explain: \_\_\_\_\_

☐ Hospitalization:

Date/s: \_\_\_\_\_

Reason: \_\_\_\_\_

☐ Diabetes

☐ Fainting

☐ Headaches

☐ Diagnosis of Migraines

☐ Psychological Concern

☐ ADHD

☐ PDD

☐ ODD

☐ Autism Spectrum

☐ Other: \_\_\_\_\_

1. Please list any daily medication/s: \_\_\_\_\_

2. Is the student presently under care of a physician for a medical or psychological condition?

\_\_\_\_\_

3. Does the student have any activity restrictions? \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_