**ANNUAL HEALTH HISTORY**

**RETURN TO IN A SEPARATE ENVELOPE “ATTENTION SCHOOL NURSE”**

STUDENT \_\_\_\_DOB GRADE

1. Allergies or allergic reactions including eczema or anaphylaxis (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is the student under a physician’s care? \_\_\_\_\_\_ If yes, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there any history of asthma / wheezing / reactive airway disease? (please explain) \_\_\_\_\_\_\_\_\_\_\_\_
2. Is there a medical history of neurological disease, seizure disorder, heart disease, hearing loss? \_\_\_\_\_\_\_

If yes, please explain on back of form.

1. Note unusual frequency of upper respiratory conditions:

\_\_\_\_\_\_\_Strep throat \_\_\_\_\_\_\_ Sinusitis \_\_\_\_\_\_\_Colds \_\_\_\_\_\_\_Earaches \_\_\_\_\_\_\_Other

1. Is there a history of major injury, concussion, surgery and hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain on back of form.

1. Eating habits: vegetarian unusual habits special needs allergies. Please circle and explain.

\_\_\_\_\_\_\_ Glasses \_\_\_\_\_\_\_ Contacts \_\_\_\_\_\_\_ Reading \_\_\_\_\_\_\_ Distance

1. Unusual sleeping patterns or problems? If yes, please explain on the back of the form.
2. Does your child have any restrictions or limitations? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please list all medications your child is taking. Include purpose and type of administration. \_\_\_\_\_\_\_\_\_\_\_

**HIGHLIGHTED ITEMS MUST BE DISCUSSED WITH THE NURSE**

I give permission for the release of information on numbers: \_\_\_\_ or all \_\_\_\_ on this form for confidential use in meetings regarding my child’s health and educational needs at Newgrange.

I desire a conference with the Nurse: \_\_\_\_\_Yes \_\_\_\_\_No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Nurse Signature Date