

Parent: PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM

**CITY OF BOSTON
PUBLIC HEALTH COMMISSION
SCHOOL HEALTH PROGRAM
HEALTH HISTORY FOR NEW ENTERERS**

Student Name _____ Date of Birth _____
Address _____ Entering Grade _____
Phone _____ Cell _____ Previous School _____
Legal Guardian: Both Parents ___ Mother ___ Father ___ Other ___
Name of Guardian _____ S. S. # _____
Name of Doctor/Health Center _____ Phone _____
Name of Health Insurance _____ Insurance # _____

1. Do any family/household members have any major health problems? () Yes () No
If yes, please describe.

2. Has this student had any of the following illnesses or conditions?

Accidents	()Y ()N	Bowel Problems	()Y ()N
Allergy	()Y ()N	Anemia	()Y ()N
Asthma	()Y ()N	Sickle Cell	()Y ()N
Diabetes	()Y ()N	Seizures	()Y ()N
T B	()Y ()N	Headaches	()Y ()N
G6PD	()Y ()N	Skin Problems	()Y ()N
Lead	()Y ()N	Behavior Problems	()Y ()N
Poisoning	()Y ()N	Heart Problems	()Y ()N
Menstrual Problems	()Y ()N	Weight Problems	()Y ()N
Learning Problems	()Y ()N	Rheumatic Fever	()Y ()N
Urinary Problems	()Y ()N	Birth Defect	()Y ()N
Kidney Problems	()Y ()N	Emotional Problems	()Y ()N
Fevers	()Y ()N		

3. Please describe any of the above problems checked YES in more detail.

(over please)

4. HEARING/VISION/SPEECH

- Has this student had frequent ear infections? ()Y ()N
- Has this student had a hearing test? ()Y ()N
- Is this student under care for a hearing problem? ()Y ()N
- Does this student have a vision problem? ()Y ()N
- Has this student had a vision test? ()Y ()N
- Does this student wear glasses? ()Y ()N
- Does this student require preferential seating due to vision/hearing problems? ()Y ()N
- Does this student have a speech problem? ()Y ()N
- Is this student receiving speech therapy? ()Y ()N

5. Does this student have any special needs that the School Health Program should be aware of? For example, is it necessary to limit activity? ___ Yes ___ No
Is this student taking any medication on a daily basis? ___ Yes ___ No
Please specify.

6. Has your child had CHICKEN POX DISEASE?
___ Yes ___ No Date of disease _____ If your child has had the chicken pox, a physician certified reliable history must be on file at the school by September 2010 for ALL students entering Nursery, KI, KII, Grades 1, 2, 3, 4, 5 & 6. A note should be on file for all students regardless of the grade.

Parent Signature

Date

Dear Parent,

There may be times when it will be necessary to share some of this information with the School Principal, your child's teacher or other members of the school faculty/staff. If there is any reason you would not want this information shared, please contact me. Please feel free to contact me if you have any questions regarding this form.

PLEASE BE SURE YOU HAVE COMPLETED BOTH SIDES, SIGN AND RETURN THE FORM TO THE SCHOOL NURSE AS SOON AS POSSIBLE.

If you have answered Yes to any question, please be sure you have explained your answer in as much detail as possible.

Thank you for your co-operation.

**Deborah McManus
School Nurse**

01/09/2009