

STUDENT'S MEDICAL HISTORY

Student Name: _____ Birth Date: _____

PAST MEDICAL HISTORY: (please fill in and explain)

Has your child had any medical problems: _____

1. Chronic problems (asthma, diabetes, ADHD, Mental Health, etc.)

2. Disabilities (special ed/medical etc.) _____
3. Has your child ever been hospitalized/had surgery/been injured:

4. Childhood illness: (Chicken pox, measles, mumps, rubella, etc.)

Has your child had any of the following: (Please check either "Yes" or "No for every question; if you can not answer a question please attach a statement explaining why.)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Eating Problem	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Weight Problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders (Anemia, Sickle Cell Disease or Trait)
<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder or ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders (Eczema, Psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (Contact/Infection)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems (Murmur, Rheumatic, Heart Disease)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems (Diarrhea, Pain, Constipation, Vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lead / Highest level _____			

Is your child taking any medications on an every day or frequent basis? Yes No Explain: _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen, or Tylenol? _____
<input type="checkbox"/>	<input type="checkbox"/>	Oral Contraceptive/Birth Control pills? _____
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics such as Penicillin, etc.? _____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health or behavioral medications (i.e. ADHD)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Vitamins (including iron pills)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma Medication? _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergy Medication? _____
<input type="checkbox"/>	<input type="checkbox"/>	TB Medication? _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic medications (i.e. insulin)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Medication? _____

Student Name: _____

Is your child **allergic** to or have they had an adverse reaction to any medications/foods/insects/animal/products:

FAMILY HEALTH HISTORY:

Please check below if any of your child's **BLOOD RELATIVES** (i.e. parents, brothers/sisters, aunts, uncles, grandparents) have had any of the following illnesses and note which relative had them:

Yes	No	ILLNESS	Relative	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, Endocrine Disorder (thyroid)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart problem, Stroke	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders including Anemia	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems including Asthma	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness (i.e. Depression)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Problems	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Infections (TB/HIV/AIDS)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Death Under the age of 50	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____	_____

I have read the materials regarding School Based Health Centers (SBHC) services and received the SBHC Privacy Notice and give my permission for my child to receive SBHC services and medical treatment. This medical history is accurate to the best of my knowledge. I understand I should inform the SBHC staff if there are any changes in my child's mental or physical health.

I give permission for the exchange of relevant medical/mental health information amongst SBHC staff, and with outside providers on an as needed basis based upon the Privacy Notice unless I object in writing. The goal of this process will be to assist in maintaining health and safety in the schools, and to coordinate my child's care. SBHC charts may be transferred to other SBHC as needed.

Signature

Date

Relationship (Parent or Legal Guardian)