



CITY OF MANCHESTER
Health Department - School Health Division

STUDENT HEALTH HISTORY
(To be completed by Parent/Guardian)

Name: (Full Legal) _____ DOB: ____ / ____ / ____ Gender: __M __F

Pregnancy & Birth

Did you have any health problems during your pregnancy?
____ Yes ____ No

Were there any complications with this child's birth or delivery? ____ Yes ____ No

What were the complications?

- ____ (Prematurity/Birth Weight _____)
- ____ Anoxia (baby didn't get enough oxygen)
- ____ Eclampsia/pre-eclampsia (mother's high blood pressure) / Toxemia (swelling)
- ____ Cesarean section
- ____ Respiratory distress syndrome
- ____ Meconium (baby's fecal matter excreted at or near birth)

Was this baby sick during the first 3 months of life?
____ Yes ____ No

GENERAL HEALTH & HEALTH CARE

In general, would you say your child's health is?

- ____ Excellent ____ Very good ____ Good
- ____ Fair ____ Poor

Has a physician / health care provider ever told you that your child had any of the following?

- ____ Diabetes
- ____ Asthma
- ____ Congenital heart disease
- ____ Down syndrome
- ____ Cerebral palsy
- ____ Attention deficit hyperactivity disorder (ADD or ADHD)
- ____ Mental retardation
- ____ Learning disability
- ____ Developmental delays _____
- ____ Sickle cell anemia
- ____ Seizures

Is your child taking ANY medication? __ Y __ N

Name of medication(s) _____

Has your child's behavior ever been assessed?

- ____ Yes ____ No ____ IEP ____ 504 Plan

Parent/Guardian Signature _____ Date _____

Eyes, Ears, Nose and Throat

- ____ Wears glasses
- ____ Three or more ear infections during the first 3 years of life
- ____ Tubes in his/her ears
- ____ Hearing loss/hearing aid
- ____ Strep throat two or more times in a year
- ____ Frequent nosebleeds

SKIN ALLERGIES

- ____ Problems with rashes
- ____ Allergies or reactions to medicines or injections
- ____ Allergy or reaction to bee sting or insect bites
- ____ Allergy to food / dyes

If yes, please explain: _____

Does your child have medication for it? __ Y __ N

Name of medication(s) _____

GASTROINTESTINAL

Does your child have any of the following?

- ____ Poor appetite
- ____ Excessive thirst
- ____ Frequent stomach aches
- ____ Frequent diarrhea
- ____ Trouble with constipation
- ____ Problem with kidneys
- ____ Problem with urine
- ____ Bladder or bowel control day or night

If yes, please explain _____

Other Problems and Illnesses

Has your child ever had any of the following?

- ____ Chicken pox. Date of disease _____
- ____ Serious accidents or injuries
- ____ Broken bones
- ____ A hospitalization overnight, other than birth
- ____ Special tests for health problems
- ____ Surgery

If yes, please explain: _____

Has your child lived in a house built before 1950 that had peeling paint? __ Yes __ No

- ____ Has your child ever been tested for lead poisoning?
- ____ Has your child ever been treated for lead poisoning?

Reviewed by (School Nurse) _____ Date _____

1. What is the primary language spoken at home? _____

2. Has your child had previous schooling (Preschool or Head Start)? No____ Yes____

Where? _____

3. Does your child have health insurance? No____ Yes____

Child's Health Insurance:

____New Hampshire Children's Medicaid

____Private Insurance

4. Does your child have a primary care provider (doctor)? No____ Yes____

Who is your child's primary care provider (doctor)? _____

When was the last time your child received a well-child checkup? (That is, a general check-up when your child was not sick or injured)_____

Was there a time during the past year when your child needed health care but was unable to get it?
No____ Yes____

5. Does your child have a dentist? No_____

Yes____ Dentist Name: _____

6. How long has it been since your child was last seen by a dentist?

____My child has never seen a dentist

____More than 6 months but less than a 1 year

____Six months or less

If your child does not have health insurance, a primary care provider (doctor), or a dentist would you like a community health care worker to contact you? No____ Yes____

Signature to allow us to call you_____

Name: _____Number:_____

Home Language:_____ Interpreter Needed No____ Yes____

Home Address: _____School:_____