

HEALTH HISTORY FORM

School Health Program

This form should be filled out by the child's parent or legal guardian. Return the completed form to your child's school nurse.

Name of Child _____ Date of Birth _____ Gender _____ Grade _____ Rm # _____
Address _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1: Name _____ Email _____
Tel # (H) _____ (C) _____ (W) _____

Parent/Guardian #2: Name _____ Email _____
Tel # (H) _____ (C) _____ (W) _____

Emergency contacts: Name _____ Relationship: _____ Telephone #: _____
Name _____ Relationship: _____ Telephone #: _____

MEDICAL HISTORY

Health concerns: Does your child have any health concerns the nurse needs to be aware of? Yes No
If YES, please describe: _____

Can your child participate in all school activities? Yes No

Allergies: Does your child have any allergies? Yes No If YES, what is your child allergic to? _____

Does your child carry an Epi Pen? Yes No

Medication: Does your child currently take medications? Yes No If YES, what medicine? _____

Past medical history: Date of last doctor's visit _____

Does or has your child received medical care for any of the following:

Asthma Diabetes Kidney Disease Orthopedic Other _____
 Concussion/Head injury Heart Disease Mental Health Seizure

MEDICAL PROVIDER INFORMATION

Primary care provider: Name _____ Clinic/Practice Name _____

Dentist: Name _____ Clinic/Practice Name _____

Other provider: Name _____ Clinic/Practice Name _____

Health insurance type: Mass Health Private Insurance Other _____

If you do not have a doctor or health insurance: Would you like assistance finding a health care provider? Yes No

Would you like assistance obtaining health care insurance? Yes No

PARENT/GUARDIAN CONSENT

The school nurse has permission to share information with school staff as s/he determines appropriate for my child's health and safety. Yes No

The school nurse has permission to share and receive the following information about my child with my child's health care provider:

Prescribed medications Yes No My child's medical conditions Yes No

Mental health/counseling concerns Yes No Other: _____



Parent/Guardian Signature

Please Print Name Here

Date

School health services are provided to CPS through a collaborative agreement with the Cambridge Public Health Department.

Last revised 10/30/17