WAYLAND PUBLIC SCHOOLS

HEALTH HISTORY

Dear Parent or Guardian,

Please complete this form for your child so that we may have the information as part of your child's confidential health record. Please return it to your child's school, attention school nurse.

PLEASE PRINT

Child's Name: _____ Date of Birth: _____

Birth Place: _____ Sex: _____

Address: _____ Home Phone #: _____

Father's Name: _____ Occupation: _____ DOB: _____

Mother's Name: _____ Occupation: _____ DOB: _____

If Guardian, so state: _____

Child's Physician: _____

Address: _____

Please list all other members of household:

Name:	Relationship	Date of Birth	Occupation

Please indicate if you child has had any of the following communicable diseases. If possible, state the year.

Chicken Pox _____ Measles _____ Poliomyelitis _____

Diphtheria _____ Scarlet Fever _____ Whooping Cough _____

German Measles _____ Mumps _____ Other _____

Has your child ever had a serious accident, surgery, or been hospitalized ? Explain_____

_____

1. Has your child had any of the following conditions? If "yes," please give the details and year noted. If the child is being treated by a physician for any condition, please indicate.

Rheumatic Fever _____ More than 3-4 cold per year _____
Kidney Disorder _____ Foot Disorder _____
Fainting Spells _____ Thyroid Condition _____
Heart Condition _____ Frequent Headaches _____
Bone Condition _____ Nosebleeds _____
Strep Throat _____ Epilepsy _____
Tuberculosis _____ Diabetes _____
Speech Problem _____
Social Adjustment Problems _____ When: _____
Any Other Serious Illness _____

2. Has your child ever been tested for tuberculosis? Yes _____ No _____
   Chest x-ray: When _____ Result _____
   Tine Test: When _____ Result _____
   Other Test: _____

3. Does your child go to an eye doctor? Yes _____ No _____

   Name: _____
   Address: _____
   Does your child wear glasses? _____
   If yes, please explain: _____

4. Has your child had any trouble with:
   Hearing _____ Ear Infections _____
   Does your child go to an ear doctor? Yes _____ No _____
   Name: _____
   Address: _____

5. Does your child have any allergies? Yes _____ No _____
   To What: _____
   (food, insect bites, other)
   If food, does your child know what he/she should not eat? Yes _____ No _____

6. Does your child take any medications regularly? _____
   Does he/she have to take any during school hours? _____
   What is the medication for? _____
   Name of medication _____

7. Is he/she under professional care for any condition? _____

_____ _____
date signature of parent or guardian