HS0001
Rev. 6/03

HEALTH HISTORY

Health Services Department
Lincoln Public Schools
Lincoln, Nebraska

Name _____ Birth Date _____ Sex _____

Parent or Guardian _____ Address _____ Phone _____

The following information is requested to assist the school staff in responding appropriately to your student's health needs. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success at school.

A. Current Health Status

1. Does your child take medicine or supplements regularly? ❑ No ❑ Yes
   Please list: _____
2. Does your child have a health condition now under treatment? ❑ No ❑ Yes
   Please list: _____ Physician _____
3. Does your child currently have allergies?
   Please list: _____
4. Any concerns about your childs health? _____
5. Date of last medical exam _____ Dr. _____
6. Date of last dental exam _____ Dr. _____
7. Does your child have current health insurance coverage? ❑ No ❑ Yes Policy Name: _____

B. Check conditions that pertained to your child or a doctor has observed and the date.

❑ Sleeping problem _____	❑ Hives _____	❑ Loss of consciousness _____
❑ Eating problem _____	❑ Chicken Pox _____	❑ Kidney problems/bedwetting ____
❑ Coordination problem _____	❑ Hay fever _____	❑ Heart problems _____
❑ Tires easily _____	❑ Asthma _____	❑ Diabetes _____
❑ Recurrent headaches _____	❑ Nosebleeds _____	❑ Rheumatic fever _____
❑ Weight problem _____	❑ Blow to head _____	❑ Pneumonia _____
❑ Eczema	❑ Broken bones	❑ Convulsions or seizures _____
		❑ Behavior/emotional concerns ____

C. Illness and Accidents

Please explain each "yes" answer. Use other side as needed.

1. Has there been more than one ear infection each year? ❑ No ❑ Yes _____
2. Have there been any hearing problems? ❑ No ❑ Yes _____
3. Has there been a vision problem? ❑ No ❑ Yes
   If yes, when last fitted for glasses? _____
4. Has your child been hospitalized or had surgery? ❑ No ❑ Yes
   If yes, please specify? _____

D. Previous History

Comments

Please explain any "yes" answers. Use other side as needed.

1. Were there any significant health concerns during pregnancy? ❑ No ❑ Yes _____
2. Was this pregnancy less than nine months? ❑ No ❑ Yes _____
3. Were there medical problems at birth? ❑ No ❑ Yes _____
4. Birth weight _____ .
5. At what age did your child walk alone? _____
6. At what age did your child say words with meaning? _____
7. Was your child ever enrolled in Lincoln Public Schools Early Childhood Special Education or Head Start?
   ❑ No ❑ Yes Date _____ School Attended _____

E. Family History

1. List who lives in the home _____
2. List any family health problems _____

_____ Completed by

_____ Relationship to child

_____ Date

Return to School Health Office. Thank you.