Concord Christian Academy
Health Office
STUDENT HEALTH HISTORY

Full Name:_____ DOB:_____ Gender:_____

Ears, Eyes, Nose & Throat

__Vision Problems __ Glasses __ Frequent ear infections
__ Tympanotomy (ear) tubes __ Hearing Loss __ Frequent strep throat infections
__ Frequent nose bleeds

Skin

__ Problems with rashes __ Sensitive skin __ Eczema

Allergies

__ Medication, if yes:_____
__ Food, if yes: _____
__ Animals, if yes, symptoms: _____
__ Dyes or soaps, if yes: _____
__ Seasonal, if yes symptoms:_____
__ Bug bites, if yes: _____

Epipens must be provided in the original pharmacy container - replace epipen when expired

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Gastrointestinal & Urinary

__ Poor Appetite/Picky Eater __ Frequent stomachaches __ Problem with kidneys
__ Urinary incontinence (wets self) __ Fecal incontinence (soils self) __ Diarrhea, how often?
__ Constipation, how often?

Other Problems & Illnesses

__ Chicken pox - if yes, date of illness: _____
__ Broken bones - if yes, please specify: _____
__ Surgery - if yes, provide name and date: _____
__ Overnight hospitalizations - if yes, why? _____
__ Elevated lead levels - if yes, when? _____

General Health

Would you say your child's health is?
__ Excellent __ Very Good __ Good __ Fair __ Poor

Has your doctor or health care provider ever told you that your child had any of the following?

__ Asthma
__ Learning disability
__Heart murmur
__ ADHD
__ Congenital heart disease
__ Diabetes, if yes: Type 1 or Type 2
__ Cerebral palsy
__ Seizures
__ Bleeding Disorder
__ Other: _____

Is your child currently taking any medications? __ Yes __ No
If yes, which medications? _____
Has your child's behavior ever been assessed? __ Yes __ No
If yes, does your child have: __ IEP __ 504 __ Behavior Plan __ IHP

Parent Signature: _____ **Date: _____**

Nurse Signature: _____ **Date: _____**

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