HEALTH HISTORY UPDATE

Dear Parent/Guardian,
*In preparation for the upcoming IEP meeting to review your child's special education program, updated health information will assist us to better serve your child's needs in school. Please answer **ALL** of the following questions regarding your child's health **in the past year**. When complete, return this form to the Health Office. Thank you.*

Student: _____ Birthdate: _____ Today's Date: _____

Person completing form: _____ Relationship: _____

Preferred phone number: ( ) _____ Email: _____

Current Primary Physician:_____ Phone: ( )_____

Other Physician(s):_____ Phone: ( )_____

Current counselor/therapist (if applicable) _____ Phone: ( ) _____

Name of health insurance: _____ ☐ None ☐ I would like assistance obtaining insurance

My child wears glasses or contact lenses for: ☐ Distance ☐ Reading ☐ Constant Last eye exam (date)_____

In the past year, has your child had ear infection, tubes, or other hearing problems? _____

Does your child have any dental problems? _____ Date of last dental exam _____

How many meals does your child eat daily? _____ How many servings of milk daily? _____

Does your child need a special diet? If yes, please specify _____

Does your child eat a variety of foods (fruits, vegetables, meat, etc.)? _____

Do you have any concerns about your child's nutrition? _____

Normal school night bedtime _____ PM Normal weekend bedtime _____

Normally awakens at _____ AM ☐ on own ☐ with alarm clock ☐ by parent/guardian

My child has ☐ no sleep problems ☐ difficulty falling/staying asleep ☐ difficulty waking up ☐ frequent nightmares

Does your child participate in organized sports? _____

Is your child active outside of school? _____ Any activity restrictions? _____

In the past year, was your child observed or hospitalized because of a head injury or concussion? ☐ Yes ☐ No

If yes, please explain _____

Do you have concerns about your child's activity level? ☐ Yes _____ ☐ No

Please list your child's extracurricular activities (scouts, music lessons, clubs, etc.) _____

Average # of hours per day spent on computer _____ video games _____ watching TV _____

Do you have concerns about alcohol, bullying, drugs, sexual activity, or smoking for your child? _____

My child consistently wears: ☐seatbelt ☐sunscreen ☐helmet ☐protective gear

In the past year, has your child had any serious illness, injury, surgery, or hospitalization? ☐ Yes ☐ No
If yes, please explain, including approximate date, treatment, outcome. _____

_____

_____

Please list current medical & psychiatric diagnoses below, or check ☐ ***NONE***

Diagnosis	Name of treating doctor/clinic	Date of last visit

Please list current medications below, or check ☐ ***NONE***

Name of medication	Prescribed for (e.g., asthma, allergies, ADHD, seizures)	Dose (mg, puffs)	When taken (morning, as needed, twice a day, bedtime)

Please list known allergies (environment, food, insect, medication, etc.) below, or check ☐ ***NONE***

Allergic to:	Reaction (runny nose, itchy, hives, rash, trouble breathing, vomiting, etc.)

Additional Comments or Concerns

Please list any other information you believe is important for us to know about your child to best serve his/her needs and any other concerns you have about your child's health, nutrition, vision, hearing, dental, etc.