

MADISON PUBLIC SCHOOLS
School Nurse's Office

HEALTH HISTORY

(To be completed by Parent(s)/Guardian)

Student Name: _____ Date of Birth: ____/____/____ Sex: ____ Grade: ____
Last First

Father's Name: _____ Mother's Name: _____

Address: _____ Phone Number: _____

Email Address: _____ (Please Print Clearly)

Please review the conditions listed below and indicate any that apply with a check (✓) Provide further information in the comment section, as to medications for the condition, healthcare provider, last episode, symptoms etc. For all checked items. Feel free to use the back of this form as needed for additional comments

✓	CONDITION	COMMENTS
	ADD/ADHD	
	Allergies	
	Food	
	Medication	
	Bee Sting	
	Environmental	
	Anaphylactic Reaction (give date)	
	Anemia	
	Asthma / Bronchitis	
	Bowel Problem	
	Cancer	
	Chicken Pox	
	Chronic / Recurrent Illness	
	Convulsions/Seizures	
	Concussion/Head Injury (give date)	
	Diabetes	
	Ear Infections	
	Eating Disorders	
	Emotional / Psychiatric Problems	
	Fainting	
	Fracture / Dislocation / Sprain	
	Frequent Colds / Sore throat	
	Frequent Headaches	
	Frequent Stomach Aches	

✓	CONDITION	COMMENTS
	Hearing Problem	
	Heart Problem	
	Hepatitis	
	Hypertension	
	Kidney/Urinary Problem	
	Lyme Disease	
	Mononucleosis	
	Neuromuscular Disease	
	Orthopedic Problem	
	Operations / Conditions Requiring Hospitalization	
	PDD / Autism	
	Scoliosis	
	Sickle Cell Anemia	
	Skin Condition	
	Speech Communication Problem	
	Strep Infections	
	Sustained illness past 3 months	
	Toothache, Dental problem	
	Vision Problem	
	None of the above	

List any other concerns you may have about your child's health and/or development:

Current Medications:

Parent/Guardian Signature: _____ Date: ____/____/____