NEWTOWN PUBLIC SCHOOLS
NEWTOWN, CONNECTICUT

STUDENT HEALTH HISTORY

Please complete all of the items below by marking the yes or no box. If an item is marked yes, INDICATE THE DATE(S) OF THE OCCURRENCE. Space is provided on the back for any additional comments you may have relative to health issues.

Student_____**DOB:**_____ **Birth Weight**_____

My child has/had:

A. CHILDHOOD ILLNESSES	**YES**	**NO**	**DATE(S)**
Chicken Pox			
Fifth Disease			
German Measles (Rubella)			
Kawasaki Syndrome			
Lyme Disease			
Meningitis			
Mumps			
Red Measles (Rubeola)			
Rheumatic Fever			
Scarlet Fever			
B. ALLERGIES			
Bee Sting			
Food			
Drug			
Epipen required			
C. CARDIOVASCULAR			
History of heart disease			
Surgical Procedures			
D. EARS, NOSE, AND THROAT			
Hearing impairment			
More than 2 ear infections/year			
Frequent nosebleeds			
More than 2 throat infections/year			
E. EYES			
History of eye problems			
Glasses for reading/distance			
F. GASTROINTESTINAL			
Frequent stomach aches			
Food allergy or sensitivity			
G. NEUROMUSCULAR			
History of neuromuscular condition			
History of seizure disorder			

H. RESPIRATORY	YES	NO	DATE (S)
ASTHMA			
Frequent coughs/colds			
Wheezing or other breathing difficulty w/exercise			
I. SKELETAL			
Broken bones			
History of scoliosis			
Unusual limp or gait			
J. SKIN			
Eczema			
Hives or rashes			
K. URINARY			
History of urinary problem			
L. SPECIAL CONSIDERATIONS			
Diabetes or any chronic condition			
Under the care of a specialist			
Special needs (OT/PT, Bracing)			
Physical Restriction			
Medication on a regular basis			
Medical/Religious Exemption			
M. HOSPITALIZATIONS			
Include reasons under comments below			

Comments:

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Revised 4/2010

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Parent/Guardian Signature Date