LOUISVILLE PUBLIC SCHOOLS STUDENT HEALTH HISTORY

TO BE COMPLETED BY PARENT OR GUARDIAN

Student ____ MALE ______ FEMALE ______ BIRTH DATE ______________ AGE ______ GRADE __________

PARENT/GUARDIAN SIGNATURE: ____ DOCTOR: _____________________________ DENTIST: ________________

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's health care provider. Please contact the school nurse if you have questions. Return the completed form to the school health office.

Allergies
- { } Seasonal hay fever
- { } Foods____________________
- { } Drugs____________________
- { } Fumes__________________
- { } Insect/Bee Stings
  - { } Has bee sting kit
- { } Animals
- { } Other____________________

Heart Problems
- { } Murmur
- { } Congenital defects*
- { } Other____________________

Respiratory problems
- { } Asthma/RAD*
  - { } Uses inhaler
- { } Frequent sore throat/colds
- { } Sinusitis
- { } Other____________________

Stomach/Intestinal problems
- { } Gastric Reflux/Heartburn
- { } Constipation
- { } Other____________________

Nutritional/Metabolic problems
- { } Anorexia/Bulimia*
- { } Over/Underweight
- { }Special diet*_______________
- { } Other________________ _____

Endocrine disorders
- { } Diabetes since when________________
- { } Hypoglycemia
- { } Thyroid problems
- { } Other____________________

Blood disorders
- { } Anemia*
- { } Hemophilia*
- { } Leukemia*
- { } Frequent nosebleeds
- { } Other________________

Orthopedic problems
- { } Scoliosis*
- { } Osgood-Schlatters
- { } Other_______________

Neuromuscular disorders
- { } Dizzy/fainting spells*
- { } Convulsions/seizures*
- { } Migraines/Frequent headaches
- { } ADD/ADHD
- { } Treated with medication
- { } Other_______________

GU conditions
- { } Incontinence*
- { } Kidney/bladder infections
- { } Severe menstrual pain
- { } Other_______________

Eye disorders
- { } Blind-Right/Left/Both eyes
- { } Glasses/Contacts
- { } Eye surgeries
- { } Other________________

Hearing disorders
- { } Hearing loss-Right/Left/Both ears*
- { } Frequent ear infections
- { } Tubes in ears
- { } Other_______________

Congenital conditions
- { } Cleft palate/hair lip
- { } Down's syndrome
- { } Growth disturbances*
- { } Other________________________

Other conditions
- { } Development delay
- { } Learning/speech disability
- { } Skin problems/eczema
- { } Burns-severe
- { } Dental/Orthodontic problems
- { } Cancer
- { } Fractures______________________
- { } Surgeries______________________
- { } Serious injuries________________
- { } Other________________________

Communicable diseases & dates
- { } Chicken Pox__________________
- { } Strep throat__________________
- { } Scarlet fever__________________
- { } Mononucleosis*_______________
- { } Tuberculosis*_________________
- { } Other________________________

Birth weight______________________

Birth problems____________________

Any close relative history of:
- { } Anemia_______________________
- { } Asthma_______________________
- { } Cancer________________________
- { } Diabetes______________________
- { } Epilepsy_______________________
- { } Heart disease___________________
- { } High/Low Blood pressure_________
- { } Scoliosis________________________

Please use this space to further explain any starred categories. ____

Does your child have any restrictions, limitations or special needs? { }**Yes** { }**No** If yes, why?____