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?_____