

REMARKS: Please explain any "yes" answer(s).

I would like to discuss my child's health with: (Please check title)

- | | |
|--|--|
| <input type="checkbox"/> School Nurse | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> School Social Worker | <input type="checkbox"/> School Psychologist |
| <input type="checkbox"/> School Guidance Counselor | <input type="checkbox"/> Principal of School |
| <input type="checkbox"/> No one at this time | |

PART TWO

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school: (e.g. seizure, severe reaction to insect sting, allergy, asthma, bleeding problems, diabetes, and heart problem)? Yes No

If yes, please describe.

2. Is there any evidence for concern in the areas listed below?

Health Area	<u>Yes</u>	<u>No</u>
Vision.....	____	____
Hearing.....	____	____
Speech/Language.....	____	____
Development.....	____	____
Physical illness/impairment.....	____	____
Adjustment.....	____	____
Nutrition.....Overweight.....Underweight.....	____	____

REMARKS: Please explain "yes" answer(s).

3. Is the student on long-term medication?..... Yes No

If "yes" please describe: _____

4. Should there be any restriction on physical activity or physical education in school?

Yes No

If "yes" specify nature and duration or restriction. _____

Signature of person completing Health History Relationship to child Date