



Sturgis Charter Public School

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Hyannis, MA 02601

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sturgischarterschool.org

HEALTH HISTORY FORM & POLICY

August 2009

Dear Parent/Guardian:

Please complete and return the attached health history form. My goal is to provide optimal health care to each student, which in turn will assist in his/her academic success. Answer each question, if applicable. The information will be kept in the health record. Please feel free to call me if you have any questions.

Sincerely,

Patricia O'Toole, RN, BS School Nurse



Sturgis Charter Public School

HEALTH HISTORY FORM

CONFIDENTIAL HEALTH HISTORY FORM FOR ENTERING STUDENTS

Please answer each question fully. Medical information is used by the staff covering the health office to better understand your child when rendering medical assistance.

Student's Name: _____ Date of Birth: _____

Grade: _____ Date of Entrance: _____ Previous school: _____

Parent/Guardian Name(s) _____

Address _____

Telephone: _____ Work or cell: _____

With whom does the child live? _____

Date of last physical _____

Physician's Name _____ Physician's # _____

Date of last dental exam _____

Dentist's Name _____ Dentist's # _____

Recent injury requiring physician's treatment Yes _____ No _____

If yes, explain _____

Recent hospital visits for illness or surgery Yes _____ No _____

If yes, explain _____

What medication, if any, does he/she take regularly? _____

NOTE: Prescribed Medication can be given at school with a signed order by a physician and parent consent. Required forms need to be filled out by parent/guardian in health office with school nurse (s). All medications are administered in the health office. Inhalers may be carried by students with a physician order and parent/guardian consent.

Does he/she have allergies requiring treatment?(bees, food, medication) Yes _____ No _____

If yes, please explain type of reaction and usual plan of action _____

History of substance abuse:
_____ Alcohol _____ Caffeine _____ Inhalants _____ Marijuana
_____ Tobacco _____

Other: _____

If yes, how was it addressed? _____

History of eating disorders (i.e.: anorexia or bulimia)? _____

Are friends or parents concerned with his/her eating habits? _____



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HEALTH HISTORY FORM

General Health History – Please check any health concerns that you or your doctor see:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> GI problems	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Chronic strep throat	<input type="checkbox"/> Headaches	<input type="checkbox"/> Painful periods
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cardiac conditions	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migrane headaches	<input type="checkbox"/> Seizure disorder

Other _____

History of mental health _____

Hospitalization for mental health problems _____

Current medications _____

Currently in counseling? Yes No Name of Counselor: _____

Does he/she seem to be:

<input type="checkbox"/> Cry often	<input type="checkbox"/> Easily upset	<input type="checkbox"/> Often angry	<input type="checkbox"/> Troubled or worried	<input type="checkbox"/> Unhappy
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Has he/she experienced any major changes in family life this past year? e.g. Moving, close family/friend with a serious illness, Loss of someone close, new arrivals (birth, adoption, step parent), divorce? Yes No

History of suicidal ideation or past attempt? Yes No If yes, When? _____

Glasses/Contacts: Yes No Date of Last Exam _____

Vision Concerns: Yes No Explain _____

Hearing Concerns: Yes No Explain _____

(Vision & Hearing Screenings are conducted for the Junior class (11th) . If you have any concerns you may contact the health office at any time to schedule a screening.)

Does he/she have any present limitations (physical or academic) requiring program modification or restrictions? Yes No If yes, please explain _____

Current: Height: _____Ft. _____ inches Weight _____lbs.

Does He/She currently have medical insurance coverage? Yes No

Name of Medical Insurance Company _____

Is medical/dental care difficult for you to obtain? Yes No

If yes, would you like assistance/information to obtain medical insurance or care? Yes No

The above information is confidential. This information may only be shared with the above student's health care providers. This information is necessary for the health and safety of the student to assist in promoting optimal health care to facilitate the academic success of each student. Thank you for your time.

Signature of Parent/Guardian completing form: _____

Date _____