

Wachusett Regional School District

HEALTH HISTORY

Dear Parent/Guardian:

In order to provide better health services to your child, we ask that you complete the following health history.

Date of last physical exam: _____ Physician: _____

Date of last dental examination: _____ Dentist: _____

Hearing/Vision Problems: _____ Hospitalizations: _____

Allergic Reactions: _____ Operations: _____

Asthma: _____ Seizures: _____

Bone/Joint disease/injury: _____

Other: _____

Diabetes: _____

Dental Problems: _____

Frequent ear infections: _____

Throat infections: _____

Frequent headaches: _____

Kidney Problems: _____

Heart Condition/Murmur: _____

Currently under treatment: YES/NO

Does your child take any medication at home or school? _____

NOTE: A physician's order and parental consent are required before any prescription medication can be given at school.

Please list any other comments or concerns that you would like to bring to the attention of the school nurse:

Please provide contact information:

Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____