PRINCETON CITY SCHOOLS
EMPOWERING EACH STUDENT FOR COLLEGE, CAREER, AND LIFE SUCCESS

Student Health History

Student Name: _____

Date of Birth: _____ **Please Check One: [ ] MALE [ ] FEMALE**

Place of Birth: _____

Home Address: _____ **Contact #** _____

HEALTH CONDITIONS:

(Please check any that apply to your child)

	Abdominal Spinal Curvature (scoliosis etc.)
	ADHD/ADD
	Allergies - Food ***
	Allergies - Medication **
	Allergies - Other:
	Anemia
	Asthma
	Behavior Problems
	Birth or Congenial Malformation
	Cancer - Type:
	Chicken Pox
	Cystic Fibrosis
	Dental Problems
	Diabetes
	Diarrhea/Constipation (chronic)
	Eating Problems
	Eczema
	Headaches (frequent)
	Hearing Aids
	Heart Disease
	Hepatitis
	High Blood Pressure
	Kidney Disease
	Meningitis or Encephalitis
	Menstrual Cycle
	Pregnancy
	Rheumatic Fever
	Seizures/Epilepsy
	Skin Rashes (frequent)
	Stool Soiling
	Substance Abuse (alcohol or drugs)
	Suicide Attempt
	Throat Infections (frequent)
	Tics/Nervous Twitches
	Urinary Tract Infections
	Wetting (day/night)
	Any Other:

****Students With food allergy/avoidance concerns must have a physician prescription on file in the building of student's attendance****

Please comment on the listed information:

_____

VISION & HEARING:

Frequent ear infections: [ ] YES [ ] NO [ ] LEFT [ ] RIGHT [ ] BOTH How Often? _____

Hearing problems? [ ] YES [ ] NO [ ] LEFT [ ] RIGHT [ ] BOTH When? _____

Ear Tubes? [ ] YES [ ] NO Date of Last Eye Exam: _____

Wears glasses? [ ] YES [ ] NO Reason: _____

INJURIES & ILLNESS: (please list any severe injuries or illness)

Injuries & Illness:	Child's Age:	Hospitalization:
_____	_____	_____
_____	_____	_____

Comments: _____

ADDITIONAL INFORMATION:

What medications are given daily or frequently? _____

This child is usually: [ ] VERY ACTIVE [ ] NORMALLY ACTIVE [ ] INACTIVE

Do you have any concern about how your child gets along with others? [ ] YES [ ] NO

Comments: _____

Do you have any other comments about this child's health, development, behavior, family, or home life that you would like to share with the school? Please Explain: _____

_____

PAST OR PRESENT SERVICES RECEIVED:

[ ] Previous Psychological Evaluation: _____ Year [ ] Special Education Support: _____ Year

[ ] Counseling or Mental Health Services: _____ Year [ ] Speech Therapy: _____ Year

Date of Last Physical Exam: _____

Date of Last Dental Exam: _____

Form Completed By: _____

Relationship to Child: _____

☐ I hereby authorize the school nurse and/or school health service specialist to share necessary health information about my child with the appropriate school staff. This information will be shared in a confidential manner.

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Parent/Guardian Signature: _____ **Date:** _____

☐ I do not give permission to share information

Parent/Guardian Signature: _____ **Date:** _____

01/30/19