

**PENNSAUKEN PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES**

HEALTH HISTORY QUESTIONNAIRE

Child's Name: _____ Birth Date: _____ Gender: male

female

Parent/Guardian Name: _____

HEALTH CONDITIONS HISTORY

	YES	NO	YEAR
Allergies			
Asthma			
Cardiac (heart) problem/condition			
Chicken Pox			
Diabetes			
Frequent colds			
Frequent Ear Infections			
Frequent headaches			
Frequent nosebleeds			
Frequent stomachaches			
Frequent throat infections			
Hearing Problems			
Hemophilia			
High fever (>104 degrees for 2 days or longer)			
Meningitis			
Seizures			
Sickle Cell Disease			
Toothaches/Dental Problems			
Tubes placed in ears			
Vision Problems			

Is your child currently taking any medication? Yes _____ No _____

If yes, please list the name of the medications and how often medication is taken:

Name of Medication	How Often is Medication Taken

Will your child need to take this medication(s) in school? Yes _____ No _____

Has your child ever been hospitalized?

Yes _____ No _____

If yes, please explain _____

Are there any additional health concerns of which you would like the nurse and/or school staff to be aware?

Primary Physician:

Name: _____

Phone: _____

**I GIVE PERMISSION TO THE SCHOOL NURSE TO SHARE ANY OF THE
ABOVE INFORMATION WITH THE APPROPRIATE SCHOOL
PERSONNEL:**

Parent/Guardian Signature: _____

Date: _____