

LEXINGTON PUBLIC SCHOOLS
Lexington, Massachusetts
School Health Services
NEW STUDENT HEALTH INFORMATION FORM

Dear Parent/Guardian:

Thank you for taking the time to fill out this brief health information history on your child as they enter the Lexington Public Schools. This information will help the school nurse better understand your child, and assist in the transition to school life. Please feel free to call and make an appointment with your building school nurse to discuss any special health care needs.

Student's Name:

_____ Last _____ First _____ MI

DOB: _____

Address: _____ **Phone#** _____

Health History

1. Has your child ever been hospitalized or had surgery? If Yes, please explain:

2. Does your child have a history of illnesses, accidents or fractures? If Yes, please explain:

3. Allergy information:	Yes	No
Is your child allergic to any medications?	_____	_____
Is your child allergic to any foods?	_____	_____
Is your child allergic to latex?	_____	_____
Is your child allergic to stinging insects?	_____	_____
Does your child have an EpiPen?	_____	_____

If yes to any of the above please give information below regarding the allergy. A life threatening allergy to food, latex, or stinging insects requires an Emergency Health Care Plan be developed and medication orders for an EpiPen be in place before entry to school. Please contact the school nurse as soon as possible.

4. Does your child have a history of asthma? Yes _____ No _____
If yes, does your child require the use of an inhaler? Yes _____ No _____

If an inhaler is needed at school, a medication order from your physician is required before entry. Please contact the school nurse as soon as possible.

5. Hearing and Vision

Has your child had a history of ear infections? Yes _____ No _____

Does your child have tubes in place? Yes _____ No _____

Does your child have a history of hearing loss? Yes _____ No _____

Does your child have a history of vision problems? Yes _____ No _____

Does your child wear glasses? Yes _____ No _____

SEE OTHER SIDE

6. Does your child take any medication on a regular basis? Yes _____ No _____

Please list:

7. Does your child have any restrictions? _____

8. General Health:	Yes	No
Frequent colds	_____	_____
Sore throats/frequent strep	_____	_____
Frequent stomachaches	_____	_____
Frequent nosebleeds	_____	_____
Seizures	_____	_____
Headaches	_____	_____
Heart murmur or cardiac issues	_____	_____
Eating/Nutrition issues	_____	_____
Bowel or bladder incontinence	_____	_____
Other: Please explain		

9. Are there any other medical or emotional issues you would like to share?

Siblings: Name Age/Grade

_____	_____
_____	_____
_____	_____
_____	_____

Parents/Guardians Names: Contact #

_____	_____
_____	_____

Physician's Name: _____ Phone# _____

Dentist's Name: _____ Phone# _____

Parent Signature: _____ Date: _____

Please return this form to the school nurse before the start of school. Thank you!