LEXINGTON PUBLIC SCHOOLS
Lexington, Massachusetts
School Health Services
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 he/she enters 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 Last Name	**First Name**	**Middle Name**

Date of Birth: _____ **Male** ☐ **Female** ☐

Address: _____ **Phone number**_____

Health History

1. **Has your child ever been hospitalized or had surgery?** Yes ☐ No ☐
   If yes, please explain: _____

2. **Does your child have a history of illnesses, accidents or fractures?** Yes ☐ No ☐
   If yes, please explain: _____

3. **Allergy information:**

Is your child allergic to any medications?	Yes ☐	No ☐
Is your child allergic to any foods?	Yes ☐	No ☐
Is your child allergic to latex?	Yes ☐	No ☐
Is your child allergic to stinging insects?	Yes ☐	No ☐
Does your child have an EpiPen?	Yes ☐	No ☐

   If yes to any of the above please give information below regarding the allergy.

   Life threatening allergy to food, latex, or stinging insects requires an Anaphylaxis Action Plan be developed and medication orders for an EpiPen to 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 ☐
   If yes, please list medication(s): _____

7. **Does your child have any restrictions?** Yes ☐ No ☐
   If yes, please explain: _____

   _____

8. **General Health:**

Frequent colds	Yes ☐	No ☐
Sore throats/frequent strep	Yes ☐	No ☐
Frequent stomachaches	Yes ☐	No ☐
Frequent nosebleeds	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Heart murmur or cardiac issues	Yes ☐	No ☐
Eating/Nutrition issues	Yes ☐	No ☐
Bowel or bladder incontinence	Yes ☐	No ☐

   Other: _____

   Please explain: _____

   _____

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

   _____

10. **Do you have a family member currently serving in the military?** Yes ☐ No ☐
    If yes, please explain: _____

    _____

Siblings:

Name_____ Age_____ Grade _____

Name_____ Age_____ Grade _____

Name_____ Age_____ Grade _____

Name_____ Age_____ Grade _____

Parents/Guardians Names:

Name _____ Contact Number_____ Mother ☐ Father ☐ Other ☐

Name _____ Contact Number_____ Mother ☐ Father ☐ Other ☐

Reliable number for school or medical emergency use:_____ Mother ☐ Father ☐ Other ☐

Physician's Name: _____ Phone number_____

Dentist's Name: _____ Phone number_____

Parent Signature: _____ Date:_____