**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 they enter the Lexington Public Schools. This information will help the school nurse better understand your child. 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?**
If yes, please explain:

**2. Does your child have a history of illnesses, accidents or fractures?**
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 epinephrine 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 _____

Please list:

**7. Does your child have any restrictions?**

If yes, please explain:

8. **General Health:**

| | | |
|---|---|---|
| Frequent colds | Yes _____ | No_____ |
| Sore throats/frequent strep | Yes _____ | No_____ |
| Frequent stomach aches | 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 behavioral issues you would like to share? Please circle if your child has a history or diagnosis: Anxiety Depression ADHD Suicidal Ideation Self Harm Bipolar Disorder Eating Disorder Autism Spectrum

Other explain _____

**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:

Physician's Name:_____ Phone number_____

Dentist's Name: _____Phone number_____

Insurance Plan Name: _____

**Parent Signature: _____Date: _____**