SOUTH KINGSTOWN SCHOOL DEPARTMENT STUDENT HEALTH HISTORY

Date: ____________________

Child's Name: ____________________ Date of Birth: ____________________

Address: ____________________

Home Phone: ____________________ Grade/Teacher: ____________________

Name of Physician/Pediatrician: ____________________

Address: ____________________ Phone: ____________________

1. Check Any Current Health Conditions:

Asthma ___ Eczema ___ Bone or Joint Problems ___ Diabetes ___ Scoliosis ___ Emotional Problems ___

Seizures ___ Heart Condition ___ Physical Disability ___ Other ____________________

2. Check Any Past Illnesses, Injuries, Conditions Operations

Strep Throat ___ Hives ___ Chicken Pox ___ Operations ___ Scarlet Fever ___ Diarrhea ___ Pneumonia ___

Sinus Infections ___ Headaches ___ Stomachaches ___ Earaches/Infections ___ Other ____________________

Teachers & support staff will be notified of health concerns on a confidential health list.

3. Medications:

Does your child presently take medication including inhalers at home? Yes _____ No _____

Please list here: ____________________

Is there any medication that needs to be taken at school? Yes _____ No _____

Please list name of medication and time to be taken. ____________________

MEDICATIONS IN SCHOOL: Must be administered by the nurse with specific written permission from the physician and parent. No child should bring medication to school.

4. Check Any Allergies:

Allergy to Bee Stings: ___ Requires Epipen ___ Requires Benadryl ___

Allergy to Foods: ___ Requires Epipen ___ List Foods ____________________

Allergy to Medications: ___ List Medication(s) here: ____________________

Allergy to Environment: ___ List Allergens & Treatment: ____________________

Any other allergies, reactions or treatments the school needs to know: ____________________

5. Vision and Hearing:

Does your child have any trouble hearing? ____________________ Tubes or hearing aides? ____________________

Does your child have difficulty seeing? ____________________ Wears glasses or contacts? ____________________

6. Dental Information: RI State Law mandates that all students in elementary schools be examined by a dentist at least once a year and once during grades 6-12. Please indicate the dentist that follows your child or the school dentist will exam your child.

Dentist's Name: ____________________ Address: ____________________ Phone#: ____________________

Date of last or next examination: ____________________

7. Other:

Is your child able to fully participate in school activities? ____________________

Is your child being treated for anything at this time? _______ If yes, please explain: ____________________

Please note any additional information in regards to your child: ____________________

Parent/Guardian Signature: ____________________ **Date:** ____________________

**** South Kingstown School District is a KIDSNET Authorized user.**

**** Parent(s)/Guardian(s) is/are responsible for notifying the bus driver and any after school programs regarding any health issues for their child(ren).**