

Warren County R-III School District

Health Information Sheet

Revised 03/2010

FOR OFFICE USE ONLY:

DBE

WRE

RBE

BHMS

WHS

Date: ___/___/___

Student's Full name: _____ M F
First Middle Last

Student's Social Security # (optional) _____/_____/_____ Date of Birth ___/___/___

Address _____

City / Zip _____ Phone: _____ - _____ - _____

Has student previously attended Warren County R-3 School District ? yes no

If yes, when _____ What grade? _____

Last school attended _____ City/State _____

Father/Guardian Name _____ Mother/Guardian Name _____

Siblings Name, Age, Grade _____

Family Medical Information: Has anyone in child's immediate family (parent, grandparent, brother, sister, etc.) had any of the following? (please check all that apply)

- | | | | |
|--------------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Severe allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Heart disease/ Stroke | <input type="checkbox"/> Seizure disorder | |
| <input type="checkbox"/> Other _____ | | | |

Student's Health History: Normal C-Section Premature

Complications/ Congenital defects: _____

Please check all that apply, include approximate date:

Student has had:

- _____ Chicken Pox
- _____ German Measles
- _____ Hepatitis
- _____ Measles
- _____ Poliomyelitis
- _____ Rheumatic Fever
- _____ Scarlet Fever
- _____ Whooping Cough
- _____ Meningitis

Student often has:

- Fever (over 105 for _____ days)
- Headache
- Colds
- Sore Throat
- Earaches
- Tires easily
- Skin problems
- Joint Pain
- Fainting Spells
- Sleep Walking
- Accidents

Student has now (or) has had:

- _____ Bleeding problem
 - _____ Cancer
 - _____ Cystic Fibrosis
 - _____ Deformity
 - _____ Muscular Dystrophy
 - _____ Heart Disease
 - _____ Multiple Sclerosis
 - _____ Artificial Limb
 - _____ Emotional/ Stress-related problems
 - _____ Seizure disorder Takes medication
- Name of Medication: _____
- _____ Diabetes Diet Controlled Takes Medication
- Name of Medication: _____

Date of student's last physical exam: ____/____/____ Physician: _____

List previous accidents, surgeries, etc. with dates: _____

Asthma - Student's symptoms are: Mild Moderate Severe
Onset (time & manner) _____
Usual cause (allergies, exercise, etc.) _____
Attack (frequency, duration, severity) _____
First Symptoms (cough, wheezing, etc.) _____
Treatment at time of attack _____

Allergies - Student allergic to: _____
Symptoms are- Mild Requires medication Daily As needed
 Seasonal Tested for cause
 Severe Desensitizing shots
Type of reaction(s): _____
Special action to help student _____

Sensitivity to insect stings/bites: Bees/Wasps Other: _____
 Severe-Systemic reaction... (needs immediate care)
 Moderate...(may have difficulty breathing)
 Mild...(severe, abnormal swelling in area of bite/sting)
Parent or close relative has severe sensitivity yes no
Special action to help child _____

Visual Problems:
 Glasses Contacts Little or No vision in Left eye Right eye
 Glass eye Left eye Right eye
 Crossed-eye Doctor states NO vision problem
Corrected by:
 Surgery Patching Exercises Time

Hearing Problems: Began talking at age 1 1/2 or before Has speech disorder
 Frequent ear infections Fluid in ears
 Wax build up in ears
 Had surgery for: _____ When? _____
 Hearing Loss (reason) _____
(congenital/disease/accident)
Percentage of Loss _____ % Left _____ % Right Wears hearing aid

Dental Problems: Has many cavities Has gum disease
 Difficulty eating Teeth do not meet properly

Eating Habits:
 Eats fresh fruit & vegetables daily Eats fast foods 3 or more times per week
 Significant weight change in last year _____ lb Gain _____ lb Loss
Food Preferences: Sweets Salty Dairy Excessive Fluids

Fatigue Level:
 Extremely energetic Normal Takes naps
 Tires easily Most noticeable in: Morning Afternoon Evening

Social/ Emotional: Very shy Has problem making friends
 Home or Social situation that may cause problem: _____

Hand most frequently used : Right Left Both equally

Physical problem that may limit physical activity: _____