

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).