POMPERAUG REGIONAL SCHOOL DISTRICT 15

Serving the Communities of Middlebury and Southbury, Connecticut

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STUDENT HEALTH HISTORY

Please complete all the items below by marking the yes or no box. If an item is marked yes, INDICATE THE DATE(S) OF THE OCCURRENCE. Space is provided on the back for any additional comments you may have relative to health issues.

Student's Name: _____

A. CHILDHOOD ILLNESSES	**YES**	**NO**	**DATE(S)**
1. Red Measles (Rubeola)			
2. Meningitis			
3. Scarlet Fever			
4. Mumps			
5. Diabetes			
6. Kawasaki Syndrome			
7. High Fever (104 degrees longer than 2 days)			
8. German Measles (Rubella)			
9. Chicken Pox			
10. Rheumatic Fever			
11. Pneumonia			
12. Streptococcal			
13. Fifth Disease			
14. Hemophilia			
B. SPECIAL HEALTH CARE	**YES**	**NO**	**DATE(S)**
15. Undergone special tests for health problems			
16. Been seen by a specialist			
17. Special needs (i.e. OT, PT, bracing)			
18. Bee sting allergy			
19. Food/drug allergy			
20. Have physical restriction			
21. On medication regularly			
C. SKIN	**YES**	**NO**	**DATE(S)**
22. Problems with rashes			
23. Bruise easily			
24. Hives or Eczema			
25. Unexplained lumps or spots			
D. EYES	**YES**	**NO**	**DATE(S)**
26. Problems with his/her eyes			
27. Glasses for reading/distance			
28. His/her eyes turn in or out when tired			
E. EARS, NOSE, AND THROAT	**YES**	**NO**	**DATE(S)**
29. Two to three episodes of ear problems in a year			
30. Trouble hearing			

EARS, NOSE AND THROAT (continued)	YES	NO	DATE(S)
31. Two or more throat infections in a year			
32. Frequent nosebleeds			
33. Frequent swollen glands			
F. RESPIRATORY	**YES**	**NO**	**DATE(S)**
34. Four to six colds in a given year			
35. Severe cough with colds			
36. Trouble getting rid of severe cough			
37. Shortness of breath at times			
38. Asthma, wheezing, other breathing difficulty			
G. CARDIOVASCULAR	**YES**	**NO**	**DATE(S)**
39. Hands/fingers that turn blue when playing hard			
40. History of heart trouble			
H. GASTROINTESTINAL	**YES**	**NO**	**DATE(S)**
41. Frequent stomach aches			
42. Difficulty digesting certain foods			
43. Frequent occurrences of vomiting			
44. Frequent episodes of constipation			
45. Frequent diarrhea			
I. URINARY	**YES**	**NO**	**DATE(S)**
46. Complains of pain during urination			
47. Strong or unusual odor of urine			
J. SKELETAL	**YES**	**NO**	**DATE(S)**
48. Broken bones			
49. Unusual limp or gait			
50. Complaint of pains in legs, arms, back or joints			
K. NEUROMUSCULAR	**YES**	**NO**	**DATE(S)**
51. Convulsions or seizures			
52. Unexplained movements or jerks			
53. Unusual staring spells			
54. Los of balance in unusual ways			
L. HOSPITALIZATIONS	**YES**	**NO**	**DATE(S)**
55. Include reasons under comments below			

Comments:_____
_____
_____

Medications: List medications your child is currently taking at home and/or needs to take in school:
_____
_____

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

_____ _____
Signature of Parent/Guardian Date

Parent Mailing (blue)
January 2008
(Assistant Superintendent's Office)