**SOUTH KINGSTOWN SCHOOL DEPARTMENT**
**HEALTH HISTORY**

Date:_____
Student's Name:_____Date of Birth:_____
Address:_____
Home Phone_____Grade/Teacher_____
Name of physician or pediatrician_____
Address:_____Phone #_____

**1.Check Any Current Health Conditions**
Asthma____ Heart Conditions____Bone or Joint Problems___ Anxiety___ Seizures____Headaches____ ADHD___Depression____
Diabetes____Scoliosis___Emotional Problems___if yes,please describe_____Physical Disability___ TB____ Eczema-____
Bleeding Disorder___Nosebleeds___other_____
****Parent is responsible to notify Bus Company/Driver and any after school programs about any health issues.**
*****Teachers will be able to view health concerns on a **confidential electronic system.**

**2.Check Any Past Illnesses, Injuries, Conditions, Operations**
Strep Throat___ Hives___Chicken Pox___Pneumonia____Lyme Disease__Headaches___Earaches or infections_____
Has your child traveled outside the US for more than 90 days? _____ If yes,where?_____
Operations (if yes, Describe) _____

**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 here name of medication and time_____
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. See medication Policy for details.

**4. Check any Allergies**
Allergy to Bee stings_____ Requires Epipen_____ Requires Benadryl_____
Allergy to Foods_____ Requires Epipen_____ List Foods_____
Allergy to Medication_____ List medications here_____
Allergy to Environment_____ List allergens and treatments_____
Any other allergies, reactions or treatments the school needs to know about_____

**5. Vision and Hearing**
Does your child have any trouble hearing?_____ Tubes or hearing aides?_____ Date tubes placed____
Does your child have difficulty seeing?_____ Wears glasses or contacts?_____

**6. Dental Information**
R.I. State Law mandates that all students in elementary schools be examined by a dentist at school at least once a year and once during grades 6-12. Please indicate here the dentist that follows your child or the school dentist will see your child.
Dentist's name:_____ Address_____ Phone#_____
Last seen or date to be seen_____

**7. Other**
Is your child able to fully participate in school activities?_____
Is your child being treated for anything right now?_____ If yes, explain_____
Please note any additional information in regards to your child_____
**South Kingstown School District is a KIDSNET Authorized user.

**Parent Signature**_____ **Date**_____
11-16-2017