FRAMINGHAM PUBLIC SCHOOLS
STUDENT HEALTH HISTORY

This form should be completed by the child's parent or legal guardian. Please return the completed form to the child's school nurse.

Student Name		**Date of Birth**	

HEALTH HISTORY	**YES**	**NO**
Were there any concerns with pregnancy, labor or delivery? If YES, please describe.		
Were the child's developmental milestones within normal limits? If NO, please describe.		
Does your child have any health concerns the school nurse needs to be aware of? If YES, please describe.		
Does your child have any allergies/sensitivities/intolerances? If YES, please describe.		
Does your child have a prescription for an Epi-pen in school?		
Does your child take medication(s) on a regular basis? If YES, what medication(s)?		
Has your child had any surgeries? If YES, please describe.		
Has your child been hospitalized for any reason? If YES, please describe.		
Does your child have a history of ear infections?		
Does your child have a history of hearing loss?		
Does your child use a hearing device?		
Does your child have a history of vision problems? If YES, please describe.		
Does your child wear glasses?		
Can your child participate in all school activities? If NO, please describe any necessary accommodations or modifications.		
Has your child received medical care for any of the following?		

	Asthma		Diabetes		Mental Health		Migraines
	Concussion/Head Injury		Heart Condition		ADD/ADHD		Seizure disorder
	Bleeding Disorder		Orthopedic Issues		Other		
	Serious accident/trauma		Bowel/Bladder Issues				

Date of last physical		Date of last dental appointment	
Parent/Guardian Signature		**Date**	