Appleton Area School District

HEALTH SERVICES * P.O. Box 2019, Appleton, WI 54911 * 920-997-1399 ext. 2106

NEW STUDENT HEALTH HISTORY FORM

A physical examination is recommended for students as they enroll for the first time.

Please return to school office upon completion.

Child's Name____________________ Birthdate__________ Age/Grade ________

School ____________________ Parent's Name____________________

Family Physician/Clinic ____________________ Date of last visit/physical exam __________

HEALTH AND DEVELOPMENTAL HISTORY

1. Was your child considered to be in good health at birth? Yes ______ No ______
   If not, please comment:

2. Do you have any concerns about your child's development? Yes ______ No ______
   If so, please comment:

3. Do you have any concern about your child's growth, height or weight? Yes ______ No ______
   If so, please explain:

4. Do you have any concerns about your child's behavior? Yes ______ No ______
   If so, please comment:

5. Is your child taking a daily medication? Yes ______ No ______
   If so, please list medication(s) and reason(s):

6. Has your child experienced any serious illnesses, accidents, injuries, or surgeries? Yes ______ No ______
   If so, when and please explain:

DENTAL HISTORY

Do you have a family dentist? Yes______ No ______ Dentist:____________________

Has your child ever visited the dentist? Yes______ No ______ Date:____________________

Comments:

VISION HISTORY

Has your child experienced any difficulties with vision? Yes______ No______

Has your child ever had a professional vision exam? Yes______ No______

Doctor:____________________

Date:__________ Results:____________________

Does your child show symptoms of eye fatigue, stress or infection such as (check all that apply):

☐ blinking ☐ squinting ☐ itching ☐ tearing ☐ redness ☐ pus discharge ☐ injury

Does your child hold books close to eyes or sit close to TV? Yes______ No______

Does your child hold books far away from eyes? Yes______ No______

Does your child close one eye or squint? Yes______ No______

HEARING HISTORY

Has your child been treated medically or surgically for ear problems or frequent ear infections? Yes_______ No_______

Was your child treated by an ENT specialist? Yes_______ No_______ ENT Specialist: ______________________________

Hearing test results (if any) ____

Has your child had ear tubes placed? Yes_______ No_______ If so, which ear? Right ______ Left ______ Both ______

Has your child experienced any difficulties with hearing such as (check all that apply):

☐ turning TV or music louder ☐ turning head to one side ☐ frequently misunderstanding instructions
☐ asking that instructions be repeated

SPEECH HISTORY

Do you think your child's speech and language development is appropriate for his/her age? Yes_______ No_______

Is your child (check all that apply): ☐ difficult to understand ☐ raspy ☐ a snorer ☐ a mouth breather?

HEALTH CONDITIONS

_____ NO, my child does not have any **diagnosed** health concerns/conditions. (please sign below)

_____ YES, my child has **diagnosed** health concerns/conditions. (please continue below)

YES	CONDITION
	ADD/ADHD
	ASTHMA
	ALLERGIES (Food, Insect, Medications, Environmental) *If yes, please list:*
	BEHAVIORAL/ MENTAL HEALTH (Depression, Anxiety, ODD, Bipolar, Mood disorder) *If yes, please list:*
	DIABETES TYPE 1 OR 2 *Please specify:*
	BLEEDING DISORDER *Please specify:*
	HEADACHES/MIGRAINES *(Please circle one)*

YES	CONDITION
	HEARING/VISION IMPAIRMENT *(Please circle one)*
	HEART CONDITION *Please specify:*
	JOINT PROBLEMS/ARTHRITIS/MUSCULOSKELETAL *Please specify:*
	KIDNEY/BLADDER/BOWEL *Please specify:*
	LOWERED IMMUNITY (Cancer, Transplant, etc.) *Please specify:*
	SEIZURES *Please explain:*
	OTHER *Please specify:*

Is there any other information about your child that would be helpful to school personnel in working with your child? Yes___ No ___
If so, please comment:

The above information is accurate and complete and may be used by school district personnel for educational purposes of my child.

______________________________ ______________________
Parent/Guardian Signature Date

For the safety of our students, this information will be placed in the Infinite Campus Health Conditions for staff notification and will be filed in the Student Health File. PLEASE REMEMBER TO PROVIDE A COPY OF STUDENT'S IMMUNIZATION RECORDS.