Student Name: _____ Student ID: _____ Date of Birth: _____

Contact Information

Student's Name_____ Sex_____

Date of Birth ____ /____ /_____ Teacher/Homeroom_____

Parent/Guardian _____ Work Phone ____ - ____ - _____

Parent/Guardian _____ Work Phone ____ - ____ - _____

Student's Physician_____ Work Phone ____ - ____ - _____

Medical History

Thoroughly review the student's medical records and other relevant documents to fill in the sections below. Consult the student's physician or Parent/Guardian for clarification, if needed.

1. Brief Health History (describe health conditions that will need attention from school health staff)

_____

_____

_____

2. Past Surgeries and Hospitalizations of Significance_____

_____

_____

3. Special Healthcare Needs _____

_____

_____

4. Student's Ability to Participate in Care_____

_____

5. Special Dietary Requirements_____

_____

_____

6. Allergies and other Intolerances_____

_____

_____

7. Family Medical Conditions of Significance_____

_____

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Medications

Review the student's medical records. Record any prescription medications, over the counter medications, vitamins, herbal remedies, supplements, and/or alternative treatments in the student's regimen.

1. Medication_____ Reason_____

   Dose_____ Frequency_____ Time(s) of Day_____

2. Medication_____ Reason_____

   Dose_____ Frequency_____ Time(s) of Day_____

3. Medication_____ Reason_____

   Dose_____ Frequency_____ Time(s) of Day_____

4. Medication_____ Reason_____

   Dose_____ Frequency_____ Time(s) of Day_____

5. Medication_____ Reason_____

   Dose_____ Frequency_____ Time(s) of Day_____

Present Illness

1. Chief Complaint (describe current condition that may warrant attention from health staff)

_____

_____

_____

2. Onset (describe when symptoms began and their nature)_____

_____

_____

3. Characteristics (describe any abnormalities occurring) _____

_____

_____

4. Course since onset (describe symptom progression using location, duration, intensity, and frequency)

_____

_____

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Review of Systems

Consult with the student/family to determine if they are experiencing any of the following conditions. Mark yes or no, accordingly. Provide notes when applicable.

Gastrointestinal	**YES**	**NO**	**NOTES**
Nausea	___	___	_____
Vomiting	___	___	_____
Vomiting Blood	___	___	_____
Heartburn	___	___	_____
Painful swallowing	___	___	_____
Abnormal stool	___	___	_____
Abdominal Pain	___	___	_____
Constipation	___	___	_____
Diarrhea	___	___	_____
Loss of appetite	___	___	_____
Early Satiety	___	___	_____
Bloating	___	___	_____

Constitutional	**YES**	**NO**	**NOTES**
Recent weight gain	___	___	lbs:_____
Recent weight loss	___	___	lbs:_____
Fever	___	___	_____
Fatigue	___	___	_____

HEENT	**YES**	**NO**	**NOTES**
Sore throat	___	___	_____
Hoarseness	___	___	_____

Cardiovascular	**YES**	**NO**	**NOTES**
Chest Pain	___	___	_____
Palpitations	___	___	_____

Respiratory	**YES**	**NO**	**NOTES**
Cough	___	___	_____
Shortness of Breath on exertion	___	___	_____
Shortness of Breath at rest	___	___	_____
Wheezing	___	___	_____

Genitourinary	**YES**	**NO**	**NOTES**
Frequent urination	___	___	_____
Painful urination	___	___	_____
Period discomfort	___	___	Date of last period:_____

Neurological	**YES**	**NO**	**NOTES**
Seizures	___	___	_____
Headaches	___	___	_____

Dermatological	**YES**	**NO**	**NOTES**
Rash	___	___	_____

Musculoskeletal	**YES**	**NO**	**NOTES**
Joint pain	___	___	_____

Psychiatric	**YES**	**NO**	**NOTES**
Depression	___	___	_____
Anxiety	___	___	_____

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I verify that all the information was collected from the student in question and transcribed in an unbiased manner. This information will be used to develop treatment plans for the child, and will not be held against them otherwise.

_____ _____

PRINTED NAME First M.I. Last DATE

_____ _____

SIGNATURE DATE