

New Milford School District

Student Health History

Name: _____ DOB _____ DATE _____

History/Physical _____ Dental _____ Immunizations Completed _____

Immunizations/Tests Needed: DPT _____ POLIO _____ MMR _____ HBV 1st _____ 2nd _____ 3rd _____
HIB 1st _____ 2nd _____ 3rd _____ Varicella _____ Mantoux _____

Prenatal/Postnatal History:

Pregnancy: Full Term _____ Premature _____ Hospitalized? _____
Labor/Delivery: Vaginal _____ C-Section _____ Birth Weight: _____ lbs. _____ ozs.
Siblings: Age _____ M/F Age _____ M/F Age _____ M/F Age _____ M/F

Parent/Sibling History:

Do the student's parents have any significant medical problems, illnesses, or allergies?
Father: _____
Mother: _____
Sibling: _____

Student Allergy History:

Reaction to Allergen

Environmental: _____
Foods: _____
Insect Stings: _____
Latex: _____
Medications: _____

Medications:

Does your child take any medication, or need an Epi-Pen for allergic reactions? _____
Daily medications: _____
PRN medications: _____
Epi Pen Jr. _____ Epi Pen Sr. _____ Last time Epi-Pen used? _____

Injuries/Operations:

Fractures: _____ Surgery: _____
Head injuries: _____ Sutures: _____
Has your child ever visited the emergency room? _____ How many times? _____
If yes, please explain? _____
Other: _____

Illnesses:

Asthma _____ Epilepsy/Convulsions _____ Respiratory Infections _____
Chicken pox _____ Febrile Seizures _____ Skin problems _____
Diabetes _____ Mononucleosis _____ Strep Throat _____
Ear infections _____ Other _____

Special Considerations:

Hearing Problems _____ Hearing Aid _____ Vision Problems _____ Glasses _____
Bowel/Bladder Problems _____
PT _____ OT _____ Speech _____
Emotional issues _____ Other _____

