Our Savior's Lutheran School

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 _____

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

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

Has your child experienced any difficulties with vision? ☐ Yes ☐ No

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

Has your child ever had a professional vision exam? ☐ Yes ☐ No

Doctor:_____ Date: _____

Results:_____

HEARING HISTORY

Has your child been treated medically or surgically for ear problems or frequent ear infections? ☐ Yes ☐ No
If so, please explain:

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? ☐ Yes ☐ No

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) *Please specify:*
	DIABETES (Type I or II) *Please specify:*
	BLEEDING DISSORDER *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 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 filed in the Student Health File.
PLEASE REMEMBER TO PROVIDE A COPY OF STUDENT'S IMMUNIZATION RECORDS.