Hanson School District

Alexandria, SD

Health Information Form

Child's Name_____ **Child's Birthdate**_____ **Age**____ **Grade**____

Who is filling out this form?

☐ Mother ☐ Father Your Name_____

☐ Other (please explain relationship to child)_____

MEDICAL HISTORY

1. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No (If no, go to question #2.)

☐ Yes (If yes, explain why and when below.)

My child was in the hospital because:	**When**
Example: Bike accident	5 years old

2. Is your child taking any **prescription medicines**?

☐ Yes - Please list the child's medicines below OR

☐ No. My child does not take any prescription medicines. (If no, go to question #3)

Does your child use an inhaler or breathing treatments? ☐ Yes ☐ No. **If YES,** please list medicine below

Name of medicine	**Amount / size of pill**	**How many pills or doses does your child take at**
Example: Dexadrine	10 mg	1 morning ____noon ____dinner 1 bed
		____morning ____noon ____dinner ____bed
		____morning ____noon ____dinner ____bed
		____morning ____noon ____dinner ____bed

3. What **over-the-counter medicines** does your child take regularly?

☐ Vitamins

☐ Herbal medicine (please list) _____

☐ Other medicines like Tylenol, Advil or something else? (please list)_____

_____

☐ None, my child does not take any over-the-counter medicines regularly.

Please turn page over

4. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)

☐ Outside or Indoor allergies, (for example: hayfever, grass, pollen, cats …) Please list below
☐ Food Allergies (for example: peanuts, milk, wheat …) Please list below
☐ Insect or Animal Allergies (for example: bees, wasps, cats…) Please list below
☐ Medicine or shots (immunization). Please list below
☐ No, my child has no allergies that I know of.

Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

My child is allergic to:	**What happens when your child has a reaction?**
Example: amoxicillian	Diarrhea (runny poop)

5. Has your child had any of the following **medical problems or injuries**? (examples in parenthesis)
Describe **your child's** problem for each ☒**Yes** on the lines at the end.

Chicken Pox	☐ Yes	☐ No	☐ Don't Know
Surgery	☐ Yes	☐ No	☐ Don't Know
Head Injury or Concussion	☐ Yes	☐ No	☐ Don't Know

Ear infections *(often has them, ear tubes, etc)*	☐Yes ☐ No
Nose problems *(sinus infections, nose bleeds)*	☐Yes ☐ No
Eye problems *(blurry vision, wears glasses, lazy eye)*	☐Yes ☐ No
----Should **wear glasses** to see ☐ far away ☐ read	
Hearing problems *(has trouble sometimes, wears hearing aid)*	☐Yes ☐ No
Mouth or throat problems *(Strep throat, swallowing problems)*	☐Yes ☐ No
Constipation *(problems having a bowel movement (BM))*	☐Yes ☐ No
Problems **peeing** *(bed wetting, pain when peeing)*	☐Yes ☐ No
Back problems *(crooked back, back pain)*	☐Yes ☐ No
Muscle and bone problems *(weak muscles, pain in joints)*	☐Yes ☐ No
Skin problems *(acne, flaking skin, rashes, hives)*	☐Yes ☐ No
Seizures *(shaking fits or convulsions)*	☐Yes ☐ No
ADD/ADHD *(problems paying attention, sitting still)*	☐Yes ☐ No
Breathing problems *(cough, asthma)*	☐Yes ☐ No
Other:	

Did you ☒**Yes** for any problems above? **Tell us more here:**_____

_____

_____

_____ _____

Signature of person filling out form Date filled out