My School District
My Town, My State, My Zip

Health Information Form

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

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.)

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

(Please use the back of this form if you have more prescription medicine.)

3. What **over-the-counter medicines** does your child take regularly?
☐ Vitamins
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None, my child does not take any over-the-counter medicines regularly.

Please turn page over

Adapted from NC health literacy tool kit-child health history form: http://www.nchealthliteracy.org/toolkit/tool11B.doc

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

Medicine 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**?

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)	☐Yes ☐ No
Nose problems (sinus infections, nose bleeds)	☐Yes ☐ No
Eye problems (blurry vision, needs to wear 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? Tell us more on the back of this page.

_____ _____

Signature of person filling out form Date filled out