MOUNT ST MARY ACADEMY
2291 ELM ST
MANCHESTER N. H. 03104
603-623-3155

STUDENT HEALTH HISTORY

Full Name: ______________________ **DOB:** __________ **Gender:** ________

Pregnancy & Birth

-Did the child or mother have any health problems during pregnancy? • Yes • No
-Were there any complications during birth? •Yes • No
-If yes, what were the complications?
- Prematurity… if checked, birth weight __________
- Anoxia (*baby did not get enough oxygen*)
- Eclampsia / pre-eclampsia (*mother had high BP*)
- Respiratory distress syndrome
- Meconium (*baby's fecal material is excreted at birth*)

Infancy

-Was your child ill during the first three months of life? • Yes • No

General Health

-Would you say your child's health is?
• Excellent • Very Good • Good • Fair • Poor
-Has your doctor or health care provider ever told you that your child had any of the following?
- Asthma
- Learning disability
- Heart murmur
- ADHD
- Congenital heart disease
- Diabetes
- Cerebral palsy
- Seizures
- Bleeding disorder

Other: ______________________________
-Is your child currently taking any medications? • Yes • No
If yes, which medication(s)? ______________________
-Has your child's behavior ever been assessed? • Yes • No
If yes, does your child have: • IEP • 504 • Behavior Plan • IHP

Parent Signature: ______________________ **Date:** ________

Nurse Signature: ______________________ **Date:** ________

Ears, Eyes, Nose & Throat

Please check each box that applies to your child
- Vision problems
- Glasses
- Frequent ear infections
- Tympanostomy (ear) tubes
  1. Hearing loss
- Frequent strep throat infections
- Frequent nosebleeds

Skin

- Problems with rashes
- Sensitive skin
- Eczema

Allergies

- Medication, if yes: ______________________
- Food, if yes: ______________________
- Animals, if yes: ______________________
- Dyes or soaps, if yes: ______________________
- Seasonal, if yes: ______________________
- Bug bites, if yes: ______________________

Gastrointestinal & Urinary

- Poor appetite / picky eater
- Frequent stomachaches
- Diarrhea, how often ______________
- Constipation, how often ______________
- Problem with kidneys
- Urinary incontinence (wets him or herself)
  - Fecal incontinence (soils him or herself)

Other Problems & Illnesses

- Chicken pox - if yes, date of illness: ____________
- Broken bones - if yes, please specify: ____________
- Surgery - if yes, provide name and date: ____________

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- Overnight hospitalization – if yes, why? ____________
- Elevated lead levels - if yes, when? ____________