

FUTURE BILINGUAL SCHOOL FOR SPECIAL NEEDS

HEALTH HISTORY FORM

Student's Date of Birth:/	Student's Name:					Current Grade:		
Country of Birth: Student's Address: City: State: Zip:		First		Middle	Last	_		
City: State: Zip: State: State	Country of Birth:					Languag	e Spoken:	
Emergency Contact: Name of Father: Phone: Condition Yes Comments						Zip:		
Condition Yes Comments Condition Yes Comments	Emergency Contact:							
Condition Allergies (food, insects, drugs, latex) Allergies (seasonal) Asthma or breathing problems Attention— Deficit/Hyperactivity Disorder Behavioral problems Developmental problems Bladder problem Bleeding problem Bleeding problem Bleeding problem Bleeding problem Bleeding problem Bleeding problem Bowel problem Bowel problem Cerebral Palsy Cystic fibrosis Dental problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. □ Yes □ No Please provide the following information Phone Condition Head injury, concussions Hearing problems or deafness Sickle Cell Disease (not trait) Speech problems Spinal injury Vision problems Usion problems The problems or deafness The probl	Name of Father: Name of Mother:							
Allergies (food, insects, drugs, latex) Allergies (seasonal) Allergies (seasonal) Asthma or breathing problems or deafness Attention- Deficit/Hyperactivity Disorder Behavioral problems Developmental problems Bladder problem Bleeding problem Bleeding problem Bleeding problem Bleeding problem Bowel problem Bowel problem Bowel problem Bowel problem Cerebral Palsy Cystic fibrosis Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information Phone Date of Last Appointment	Prione: Prione:							
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Asthma or breathing problems Hearing problems or deafness Attention-Deficit/Hyperactivity Disorder Heart problems Behavioral problems Lead poisoning Developmental problems Muscle problems Bladder problem Seizures Bleeding problem Sickle Cell Disease (not trait) Bowel problem Speech problems Cerebral Palsy Spinal injury Cystic fibrosis Surgery Dental problems Vision problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. \(\text{\text{Yes}} \) No Please provide the following information \(\text{Phone} \) Phone \(\text{Date of Last Appointment} \)	insects, drugs, latex)				concussions			
Attention- Deficit/Hyperactivity Disorder Behavioral problems Developmental problems Bladder problem Bleeding problem Bleeding problems	Allergies (seasonal)				Diabetes			
Attention- Deficit/Hyperactivity Disorder Behavioral problems Developmental problems Bladder problem Bladder problem Bleeding problem Bowel problem Cerebral Palsy Cystic fibrosis Dental problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. \[\textstyle \t								
Deficit/Hyperactivity Disorder Behavioral problems Developmental problems Bladder problem Bleeding problems Bleedin	•				deafness			
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Bladder problem Bleeding problem Bleeding problem Bowel problem Cerebral Palsy Cystic fibrosis Dental problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information Phone Date of Last Appointment	Behavioral problems				Lead poisoning			
Bleeding problem Sickle Cell Disease (not trait)	-				Muscle problems			
Bowel problem Speech problems Cerebral Palsy Spinal injury Surgery Dental problems Vision problems Vision problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information Phone Date of Last Appointment	Bladder problem				Seizures			
Cerebral Palsy Cystic fibrosis Surgery Dental problems Vision problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. \(\text{Yes}\) No Please provide the following information Phone Date of Last Appointment	Bleeding problem							
Cystic fibrosis Dental problems Vision problems Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. \(\text{Yes}\) No Please provide the following information Phone Date of Last Appointment	Bowel problem				Speech problems			
Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information Phone Date of Last Appointment	Cerebral Palsy				Spinal injury			
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oxygen support, hearing aid, dental appliance, etc.): List all prescription, over-the-counter, and herbal medications your child takes regularly: Check here if you want to discuss confidential information with the school nurse or other school authority. Please provide the following information Phone Date of Last Appointment	Dental problems				Vision problems			
Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information Phone Date of Last Appointment	oxygen support, hearing aid, dental appliance, etc.):							
Please provide the following information Phone Date of Last Appointment								
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Pedial dician / normary care provider	Pediatrician/primary care provider			rnone		Date of L	asi appointment	
	Specialist							
	Dentist							
Case Worker (if applicable)								