

SUDBURY PUBLIC SCHOOLS
Interval Health History

Name _____

Grade _____

Dear Parent/Guardian: This year, in order to keep your child's health record up to date and to provide better health services to your child, we ask that you complete the following form and return it to your school nurse.

1. Accidents (explain) _____
2. Allergies _____
3. Asthma _____
4. Bone or Joint Disease _____
5. Seizure Disorder _____
6. Diabetes _____
7. Dental Concerns _____
8. Ear Infections _____
9. Throat Infections _____
10. Frequent Headaches _____
11. Frequent Stomachaches _____
12. Heart Disease/Murmur _____
13. Urinary Tract Concerns _____
14. Bowel Concerns _____
15. Menstrual Concerns _____
16. Hospitalizations _____
17. Operations _____
18. Is your child being treated for:

Posture _____	Date _____
Vision _____	Date _____
Hearing _____	Date _____

What medicine, if any, does your child take?

Does your child have any present physical limitations?

Please add any other problems or comments you would like to bring to the attention of the school nurse. Use the reverse side if needed.

Signature _____

Date _____