

Solomon Schechter Day School of Greater Boston

2011-2012 HEALTH HISTORY UPDATE (to be filled out by parent annually)

NAME OF CHILD _____ BIRTHDATE ____/____/____ GRADE/CLASS _____

NAME OF CHILD'S PHYSICIAN(S) _____ PHONE () _____

_____ PHONE () _____

NAME OF CHILD'S DENTIST _____ PHONE () _____

NAME OF CHILD'S ORTHODONTIST _____ PHONE () _____

HEALTH PLAN _____ SUBSCRIBER _____ ID # _____

PLEASE BE SURE TO FILL OUT EVERY LINE IN THIS SECTION COMPLETELY!

PERMISSION FOR MEDICATIONS

I GIVE PERMISSION FOR TRAINED SCHOOL PERSONNEL TO DISPENSE THE FOLLOWING MEDICATIONS TO THE CHILD LISTED ABOVE, WHEN INDICATED, ACCORDING TO STANDING ORDERS OF THE SCHOOL PHYSICIAN: (CHECK ONLY THOSE YOU WISH TO HAVE DISPENSED)

ACETAMINOPHEN _____ (I.E. TYLENOL)
IBUPROFEN _____ (I.E. ADVIL, MOTRIN)
DIPHENHYDRAMINE _____ (I.E. BENADRYL)

PARENT/GUARDIAN SIGNATURE _____

HEALTH HISTORY (CHECK, GIVING APPROXIMATE DATES AND DETAILS, INCLUDING PREFERRED TREATMENTS AND MEDICATIONS):

_____ CHICKENPOX _____

_____ BLEEDING/CLOTTING DISORDERS _____

_____ DENTAL/ORTHODONTIC PROBLEMS _____

_____ DIABETES _____

_____ FREQUENT EAR INFECTIONS _____

_____ HEART DEFECT/DISEASE _____

_____ GASTROINTESTINAL
DISORDERS _____

_____ OPERATIONS/SERIOUS INJURIES _____

_____ ORTHOPEDIC PROBLEMS _____

_____ SEIZURES _____

_____ SKIN PROBLEMS _____

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_____ FREQUENT STREP THROATS/TONSILLITIS _____

_____ URINARY TRACT PROBLEMS _____

_____ VISION/HEARING PROBLEMS _____

_____ OTHER (NOTE: ALLERGIES/ASTHMA ARE LISTED BELOW) _____

_____ HAY FEVER _____

_____ SEVERE IVY ALLERGY _____

_____ INSECT/BEE STING ALLERGY _____ EPIPEN? _____

_____ MEDICATION ALLERGIES: LIST MEDICATIONS AND REACTIONS _____

_____ FOOD ALLERGIES: LIST FOODS, REACTIONS, TREATMENT _____

_____ EPIPEN? _____

_____ ASTHMA _____

_____ OTHER ALLERGIC PROBLEMS _____

FOR FEMALES: HAS CHILD MENSTRUATED? ___ YES ___ NO IF YES, ANY PROBLEMS? _____

CURRENT MEDICATIONS: LIST **ALL** CURRENT MEDICATIONS TAKEN, WHETHER AT HOME OR IN SCHOOL
(OR "ONLY WHEN NECESSARY")

NAME OF MEDICATION REASON FOR TAKING DOSE HOW OFTEN WHAT TIMES TO BE TAKEN AT SSDS?

- 1.
- 2.
- 3.
- 4.
- 5.

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN'S ADVICE? _____

SIGNATURE OF PARENT _____ DATE _____

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