FOR PARENT TO COMPLETE:

LINE MOUNTAIN SCHOOL DISTRICT

Line Mountain Middle/ High School
Jeffrey Roadcap, Principal
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Mrs. Cindi Grimm R.N., B.S.N.

Line Mountain Elementary School
Jeanne Menko, Principal
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Mrs. Joanne Snyder, R.N., B.S.N

HEALTH HISTORY

Student name_____DOB_____Age_____ Grade_____ Homeroom_____
Name of person child lives with: _____Relationship_____
Address_____
Father's name:_____ Mother's name:_____
Home Phone_____ Mtr. Cell Phone _____Ftr. Cell Phone_____
Name of family physician & address_____
_____ Physician phone # _____
Is your child currently under a doctor's care for any long-term or recurring disease or illness? If yes, please explain
_____
Does your child take medication at home on a regular basis? ____*If Yes, Explain*_____

Will your child need to take medication during school hours? YES ☐ NO ☐ (*IF YES, PLEASE REQUEST AND REVIEW LINE MOUNTAIN'S MEDICATION FORM AND POLICY)*

Did your child have any problems at or during birth, ie premature, breathing problems, birth defects? If other, please explain _____
_____

Child's Family: Please indicate if condition applies to child's mother, father, grandparent, brother/sister. (M=mother; F=father, MGM=maternal grandmother; MGF=maternal grandfather; PGM=paternal grandmother; PGF=paternal grandfather S=sister; B=Brother

	YES	NO		YES	NO
Alcoholism/Drug Abuse			**Hepatitis**		
Cancer			**High Blood Pressure**		
Diabetes			**Tuberculosis**		
Emotional/Mental problems			**Other**		
Heart Disease					

Has YOUR CHILD had or been diagnosed with any of the following? If so, at what age?

	YES	NO	AGE		YES	NO	AGE
Chickenpox				**Scarlet Fever**			
Asthma				**Reyes Syndrome**			
Attention Deficit Disorder				**Seizure Disorder**			
Rheumatic Fever				**Other**			

MISCELLANEOUS	YES	NO	EXPLAIN
Allergies to: Medication, Food, Insects	____	____	_____
Cancer.....	____	____	_____
Dental problems.....	____	____	_____
Diabetes.....	____	____	_____
Drug/Alcohol problems.....	____	____	_____
Eating problems-gain or loss.....	____	____	_____
Frequent complaints of illness	____	____	_____
Heart problems.....	____	____	_____
High Blood Pressure.....	____	____	_____
Hospitalizations/Surgery.....	____	____	_____
Learning problems.....	____	____	_____
Skin disorder.....	____	____	_____
Speech Problems.....	____	____	_____

ABDOMINAL CONCERNS	YES	NO	EXPLAIN
Hernia.....	____	____	_____
Kidney injury/operation.....	____	____	_____
Menstrual difficulties.....	____	____	_____
Spleen injury /operation.....	____	____	_____
Stomach/Bowel problems.....	____	____	_____

EENT CONCERNS	YES	NO	EXPLAIN
Frequent earaches.....	____	____	How often_____
Frequent sore throats.....	____	____	How often_____
Hearing problems.....	____	____	_____
Wears hearing aid.....	____	_____	Which ear?_____
Tubes in ears.....	____	_____	Which ear?_____
Vision problems.....	____	____	Glasses/Contacts?_____

NEUROLOGICAL CONCERNS	YES	NO	EXPLAIN
Headaches.....	____	____	How Often?_____
Head Injury.....	____	____	_____
Fracture/broken.....	____	____	_____
Concussion.....	____	____	When?_____
Unconsciousness.....	____	____	How long?_____
Neck injury.....	____	____	_____
Sleeping problems.....	____	____	_____

ORTHOPEDIC CONCERNS	YES	NO	EXPLAIN
Fractures/broken bones.....	____	____	_____Left/Right
Muscular condition/disease.....	____	____	_____
Scoliosis.....	____	____	_____
Other.....	____	____	_____

Any reason *your child* can NOT fully participate in gym? If so, please explain._____
Any special concerns which you would like to bring to the attention of the nurse or physician? If so, Please explain. _____

***Parent/guardian signature*_____*Date*_____**

REMINDER: PLEASE RETURN THIS FORM TO THE SCHOOL NURSE TOMORROW.