SCHOOL HEALTH QUESTIONNAIRE/REPORT

Boulder Valley School District Re-2

A health history is part of the student's evaluation. It helps to provide a complete overview of your child and to assess health/educational needs.

Please complete this form IMMEDIATELY AND RETURN to your child's school nurse consultant.

Feel free NOT to answer any questions. This information is confidential.

PLEASE FILL OUT FRONT AND BACK

School Nurse Consultant: _____ Voice Mail #:_____

Today's Date: _____

Student Name:_____ School: _____ Gender:_____ Grade: _____

Birthday: _____ Age:_____ Teacher:_____

Student lives with: Both Parents _____Mother Only _____ Father Only_____Joint Custody_____ Other _____

Person filling out this form: _____ Relationship to student:_____

Cell Phone: (____) _____- _____ Work Phone (_____) _____-_____ HomePhone: (_____) _____- _____

Current Medical Insurance: _____ Primary Care Provider :_____

BIRTH HISTORY: Adopted at age _____ Mother's age at birth _____ Early history unknown _____ _____

Pregnancy was _____healthy or complicated because _____

Prenatal care started at _____ months. Problems during pregnancy were _____

_____Labor & delivery healthy Born at ___ months Weighed ___lb. ___oz. C-Section because _____

_____Difficult Delivery? _____

Describe any newborn complications, breathing problems, trauma, or special needs:

_____

Did your child require a longer hospital stay? ___ If so why? _____

GROWTH & DEVELOPMENT:

Were there any early childhood concerns about your child? _____

Age: Crawled @ _____ Walked @ _____ Talked (words @ _____ sentences @_____) Toilet Trained @ _____

Wet bed until age _____ Soiled pants until age _____ In diapers still _____ Other _____

Describe balance, coordination, or muscle concerns _____

Vision problems: Explain _____

Hearing problems: _____ Many ear infections (ages _____) Tubes @ age _____

CURRENT HEALTH

Date of last dental care _____ Problems? _____ Routine Exam? Yes ____ No _____

Date of last physical exam _____ If known, please give: Height _____ Weight _____

Medical diagnosis? _____

_____ Diagnosed by: _____ Date: _____

Currently on following Medications: _____ for _____

Considered _____ADD _____ ADHD by ___family ____teachers Diagnosed at age _____ by _____

Medication/Treatment History is_____

_____

□ **Allergies** □ Moderate □ Life Threatening Triggers are _____
□ **Asthma** □ Moderate □ Life Threatening Triggers are _____
Head injuries/Seizures/Hospitalizations/ER Visits (Describe & give ages) _____
_____
_____
_____
Has student ever been unconscious? ____ For how long? _____ At age _____ Reason _____
Describe any other **on-going** health concerns and care _____
_____
Who Provides Care? _____

NUTRITION: Appetite is ____Good ____Fair ____Poor ____Picky. Drinks mostly _____ Is vegetarian _____
Weight/Eating concerns? _____
Eats breakfast ____Usually ____Sometimes ____Never. Snacks mostly on _____
Daily has: ____Protein/Meat ____Veggies ____Fruits ____Grains ____More than one soda/day ____ Too many sweets
Meals family eats together? ____Breakfast ____Dinner ____ Weekends only ____Eats on our own ____Usually watch TV at meals

FITNESS: Student is physically ___Quiet ___Active ___Very Active _____hours of TV/Computer/videos per day
Prefers to do things __Indoors __Outdoors ___Both Usually does activities ___Alone ___With friends ___Both
List organized/team sports _____ ___At school ___Outside school
Describe exercise/fun activities _____
Describe social interactions_____

SLEEP: On school nights: Asleep by _____PM Up by _____AM ____Has trouble sleeping ____Has nightmares
____Stays up too late ____Often has trouble getting up in the morning ____Often seems tired during the day
Other sleep concerns_____

Explain SIGNIFICANT STRESSES (emotional concerns in student's life – family, school, friends, abuse, losses, etc. and give ages)_____
_____
Describe Counseling □ Past □Current Name of Counselor _____
_____
Describe attitude toward school_____

DESCRIBE OTHER CONCERNS YOU HAVE ABOUT YOUR STUDENT_____
_____
_____
Do you need assistance in meeting your student's physical/dental/mental/other health concerns? If so, describe:
_____

HEALTH HABITS - MIDDLE AND HIGH SCHOOL ONLY

Describe any employment _____
Number of hours student works _____Weekdays _____Weekends _____Evenings
Do you have any concerns about your student regarding the following areas?
□ Cigarettes □ Street Drugs □ Chewing tobacco □Sexual activity □Alcohol □Driving Safety
If yes, explain_____