.

For All New Students

FR. JOHN V. DOYLE SCHOOL
343 South Main Street Coventry, R.I. 02816
Phone: 401-821-3756 Fax: 401-828-8513

Start date: _____ 20_____
Grade:_____ Homeroom:_____

For School Use Only
IHP:

HEALTH HISTORY FORM FOR NEW STUDENTS

Please complete this form and return to the school nurse.

Student's Name _____ Date of birth ____/____/_____ M__ F__
(mm) (dd) (yyyy)

HEALTH CONCERNS (please check any that apply)

____eye problems, poor vision, crossed eyes
____wears glasses/contacts
____frequent ear infections
____tubes in ears
____poor hearing
____wears hearing aid
____speech/language problems
____frequent headaches
____frequent nosebleeds
____dental appliance (braces, palate expander)
____frequent colds
____prosthesis (indicate type)_____
____clumsiness in walking
____clumsiness in running
____difficulty using pencil/crayons
____difficulty using scissors
____temper tantrums
____overweight/underweight
____problems sitting still, paying attention
____Other: _____

SIGNIFICANT HEALTH HISTORY

(please indicate date(s) your child has had any of the following and circle any current conditions)

____Allergies*(see next section)
____Anemia
____Asthma
____Attention Deficit Disorder
____Birth Defects
____Bleeding Disorder
____Bone, joint, muscle problem
____Bowel/Bladder problems
____Cancer
____Chicken Pox
____Diabetes
____Eczema, psoriasis, skin rashes
____Fractures(broken bones)_____
____Heart disease
____Heart Murmur
____Hepatitis
____Kidney Disease
____Kidney/Bladder Problem
____Lead poisoning
____Lyme Disease
____Migraines/Headaces
____Mono
____Meningitis
____Pneumonia
____Poisoning/Overdose
____Psoriasis
____Rheumatic Fever
____Scarlet Fever
____Seizure disorder(indicate kind)
____Sickle Cell Disease
____Strep Throat
____Surgeries: _____
____TB(Tuberculosis)
____Other: _____

(over, please)

ADDITIONAL INFORMATION

Please indicate if any of the following are present:

☐ ***Allergies**: Please indicate specific allergen along with reaction. Ex: Milk (rash), Peanuts (anaphylaxis)

_____

_____

IS AN EPI PEN REQUIRED FOR THIS STUDENT? ☐yes* ☐no

(*If Yes, you and the prescribing physician will need to complete an anaphylaxis treatment form in order to use in school).

Medication: Please indicate name and reason for any daily/weekly/monthly medications. Ex: Albuterol (asthma)

_____

_____

Will medication(s) be necessary in school? ☐yes* ☐no

(*If Yes, a consent form completed and signed by a physician is required for each medication)

Immunization Record: Please attach an updated record from your child's physician

Name of child's doctor: _____ Doctor's phone number:_____

Name of child's dentist: _____ Dentist's phone number: _____

Do you have any comments or concerns about your child's health, development, behavior, family or home life that you think might have an effect on him/her in school? ☐Yes* ☐No *If yes, please explain:

_____

_____

_____

CONTACT INFORMATION

Just in case I need to reach you during the day, please provide the following.

Mothers' name:_____ **Home number:** _____

Name of employer:_____ **Work number:** _____

Cell number: _____

Fathers' name:_____ **Home number:** _____

Name of employer:_____ **Work number:** _____

Cell number: _____

Thank you for taking the time to complete this form. Please return this form along with any registration materials to the school. If you have any further questions or concerns, please don't hesitate to contact me. You can ask for me at the school on Monday-Friday 8:00-2:30pm at 821-3756 or by email bethanygelormini@fjvd.org