East Providence School Department

This information will become part of your child's educational record and may be shared with appropriate school personnel for educational and safety purposes.

Name of Child _____Date of Birth_____ Male_____ Female_____ Grade: _____
Address_____Home Phone_____
Physician Name_____Physician Number_____ Dentist Name _____
Name of prior school, if any:_____ City/Town, State:_____

HEALTH CONCERNS/HEALTH HISTORY

Please check any health concerns that apply and provide additional information on lines:

ALLERGIES: Please check and list name of allergen/s
□ Food:_____ □ Medication Allergy:_____
□ Insect: _____ □ Environmental:_____

Has your child experienced any of these allergic symptoms? :
□ Rash □ Swelling □ Hives □ Trouble Breathing
□ Vomiting □ Diarrhea □ Local Reaction
Is an Epipen prescribed for school? ___ Yes ___ No
□ Other medicines prescribed: _____
□ My child follows a special diet :_____
□ My child requires allergy exposure precautions in the classroom/cafeteria: □ Peanut/Nut Free Classroom/Table □ Other

ASTHMA/ RESPIRATORY CONDITIONS:
□ Triggers:_____
□ Needs Inhaler at School □ Yes □ No
□ Frequent colds □ Nosebleeds □ Frequent Strep Throat
□ Bronchitis □ Pneumonia □ Other: _____

BLOOD DISORDERS:
□ Sickle cell disease □ Anemia □ Hemophilia
□ Other blood disorder/condition: _____
□ Precautions/Restrictions:_____

EMOTIONAL/BEHAVIORAL CONCERNS:
□ ADHD
□ Other Diagnosis: _____
□ Treatment/Medication: _____

CONGENITAL DISORDERS:
□ Cystic Fibrosis □ Spina Bifida □ Other: _____

DENTAL CONCERNS:
□ Multiple cavities/fillings
□ History of tooth injury: _____
□ Wears braces/corrective device: _____
□ Other dental concerns: _____

DIABETES
□ Type I □ Type II
□ Needs medication at school: _____
□ Needs blood sugar monitoring at school: _____

□ **MEDICATIONS:**
Taken at home: _____
_____
_____
Taken at school: _____

*****All medications given at school require a signed physician's order and parental/guardian permission. Please inquire with school nurse.**

DIGESTIVE/ELIMINATION
□ Frequent stomachaches
□ Constipation □Diarrhea □ Bladder/Bowel control problems
□ Other concerns/conditions _____

HEART CONDITION:
□ Type: _____
□ Physical Restrictions: _____
□ Other Precautions: _____

HEARING DIFFICULTIES:
□ Hearing loss, type: _____
□ Frequent ear infections
□ Ear tubes, Presently in □ Right ear/ □ Left ear
□ History of ear tubes (removed) □ Right ear/ □ Left ear
□ Assistive hearing device: _____
□ Classroom accommodations:
□ Special seating_____ □ Other:_____

HOSPITALIZATION:
□ Reason: _____ Date: _____
□ Treatment: _____

INJURIES REQUIRING MEDICAL TREATMENT:
□ Type of Injury: _____Date:_____
□ Treatment: _____

SKELETAL/MUSCULAR CONDITIONS and MOBILITY NEEDS:
□ Muscular Dystrophy
□ Other Muscular/Skeletal conditions: _____
□ Wears/uses orthopedic device: _____
□ Needs wheelchair
□ Classroom accommodations:_____

NEUROLOGICAL CONDITIONS:
□ Frequent headaches □ Migraines
□ Cerebral Palsy □ Other neurological condition: _____

SEIZURE CONDITIONS:
□ Grand mal □ Absence (petit mal) □ Complex
□ Frequency of seizures:_____
□ Date of last seizure: _____
□ Medication at school: _____

SURGERIES:
□ History of surgery: Date:_____ Type: _____
□ Other: _____

VISION PROBLEMS:
□ Difficulty seeing: ____far ____ close
□ Lazy eye □ Strabismus (cross eye)
□ Wears: __glasses __contacts
□ Date of last eye exam: _____

□ Other medical conditions or limitations not listed above: _____

Parent/Guardian Signature:_____ **Date:** _____