New Prague Area School – Health Services
Annual Student Health History Update for Grades 1 – 12

_____ _____ _____
Student's Full Name **School** **Grade**

Has your child had any changes in his/her health during the past year? ☐ **no** ☐ **yes**
If yes, describe_____

Has your child had any contagious disease or surgery within the last year ? ☐ **no** ☐ **yes**
If yes, describe_____

Does your child take medication (including herbal, OTC, and prescription) **on a regular schedule?** ☐ **no** ☐ **yes**
*Medication Administration Form needs to be completed for a student to receive any medication during the school day.
Medication _____ **For the treatment of** _____

Has your child received any immunization(s) within the past year? ☐ **no** ☐ **yes**
Tdap (mo/day/yr) _____ **MMR (mo/day/yr)** _____ **Hep. B (mo/day/yr)** _____
Varicella or chicken pox history(mo/day/yr) _____ **Other (Menactra, Hep. A, HPV**
_____

Is your child able to participate in regular physical education? ☐ **no** ☐ **yes**
Limitations/concerns _____

In order to better maintain your child's health & safety, please check any or all areas of concern:

- ☐ **Asthma**
- ☐ **Allergies**
  - ☐ **Bee sting (mild or severe)**
  - ☐ **Food** _____
  - ☐ **Hayfever/Seasonal**
- ☐ **Diabetes**
- ☐ **Emotional/Behavioral**
  - ☐ **ADD(H)**
  - ☐ **Anxiety**
  - ☐ **Depression**
  - ☐ **Other**_____
- ☐ **Epilepsy/Seizures**
- ☐ **Headaches**
  - ☐ **Treated with** _____
- ☐ **Hearing concerns**
  - ☐ **Wears hearing aid (L R)**
  - ☐ **Earaches**
  - ☐ **Loss of hearing (L R)**
- ☐ **Injury/Trauma**
  - ☐ **Head**
  - ☐ **Other** _____
- ☐ **Heart Condition**
  - ☐ **Dizziness/Fainting**
  - ☐ **Other**
- ☐ **Nosebleeds** ___ **frequent**
- ☐ **Sinus Infections** ___ **frequent**
- ☐ **Sore throats/colds** ___ **frequent**
- ☐ **Vision Concerns**
  - ☐ **Wears glasses**
  - ☐ **Wears contacts**
  - ☐ **Other** _____
- ☐ **Stomach concerns**
  - ☐ **Stomachaches**
  - ☐ **Ulcers**
  - ☐ **Other**
- ☐ **Weight concern**
  - ☐ **Gain**
  - ☐ **Loss**
- ☐ **Other Health Issues**
  - ☐ _____

☐ **Check here if your child does not have any health concerns.**

I understand that the information provided above will be shared in a confidential manner with appropriate staff members who need to know in order to provide for the health needs and safety of my student. I will keep the school informed of any changes in health status or contact information. Information provided on this form is true and accurate. This information may also be shared with summer school staff when appropriate.

_____ _____
Parent/Guardian Signature **Date**