St. Francis Area Schools
4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

Parent/Student Health Questionnaire

Information will be reviewed by the licensed school nurse and kept in the student's confidential file.

GENERAL INFORMATION

Student's Full Name _____

☐ Male ☐ Female Birth Date_____ Grade_____

Street Address _____ PO Box _____ Apt, Lot # _____

City _____ Zip Code_____ Home Phone _____

Primary Parent/Guardian #1_____ Cell Phone_____Work Phone _____

Primary Parent/Guardian #2_____ Cell Phone_____Work Phone _____

Household Members	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HEALTH HISTORY

Please check if any of your blood relatives (parents/brothers/sisters/grandparents) have had the following conditions:

Condition		Condition		Condition		Condition	
ADHD/ADD		Diabetes		Seizures		Bipolar disorder	
Tourette Syndrome		Tuberculosis		Alcoholism		Schizophrenia	
Learning disability		Heart problems		Drug abuse		Suicide	
Cancer (type)		Genetic/inherited disease (type)		Depression		Other	

DEVELOPMENTAL HISTORY *(Grades K-5 Only)*

List age when your child:

Babbled and cooed _____ Crawled _____ Walked _____ Talked in sentences _____

Became toilet trained _____ Accidents during the day: Urine ☐ Yes ☐ No; Stool ☐ Yes ☐ No

History/concern of developmental delay ☐ Yes ☐ No If yes what? _____

_____

Are height and weight patterns typical? ☐ Yes ☐ No Concerns _____

Childhood illnesses (list)_____

Childhood injuries (list) _____

Sleep patterns

How many hours per night ____ Apnea ☐ Yes ☐ No Snores ☐ Yes ☐ No Awakens during the night ☐ Yes ☐ No

PAST MEDICAL HISTORY

Was the child a normal pregnancy? ☐ Yes ☐ No Concerns (explain) _____

Did the mother use:
Tobacco ☐ Yes ☐ No Alcohol before pregnancy ☐ Yes ☐ No Alcohol during pregnancy ☐ Yes ☐ No

Length of pregnancy/gestational age _____weeks birth weight _____pounds _____ounces

Was the labor/delivery typical? ☐ Yes ☐ No Concerns/difficulties for mother (explain) _____

Infant had difficulties at birth or shortly after? ☐ Yes ☐ No (explain) _____

Child was adopted? ☐ Yes ☐ No Age of Adoption _____ Country of Birth _____

Hospitalizations (explain) _____

Surgeries (explain) _____

Significant fall or injury to the head that required a physician visit. (date/describe)_____

_____

Special tests for health problems i.e.: EKG, MRI CT, EEG Genetic testing, psychological/neurological testing (explain/results)

_____

Test were conducted by_____ Phone _____

CURRENT HEALTH STATUS

Currently how is the student's overall health? ☐ Fair ☐ Good ☐ Excellent

Health concerns/problems/illness (describe) _____

Medical diagnoses_____

Injuries _____

Activity restrictions_____

Is a medic alert bracelet/necklace worn? ☐ Yes ☐ No

Complimentary therapies or herbal/food supplements _____

MEDICATIONS

What are the medications ***currently*** being taken?

Medication	Why is it taken?	Dose	How often?	What time of day?

Allergies or adverse reactions to medications
Are there any medications the students has taken that have caused them problems?

Medication	Reason no longer taking medication

Food allergies/sensitivities or other allergies, i.e. include bee stings, latex allergy, lactose intolerance etc.

Food or substance	Reaction or treatment

REVIEW OF BODY SYSTEMS

Head Normal size ☐ Yes ☐ No Headaches ☐ Yes ☐ No Migraines ☐ Yes ☐ No

Nose/Throat Normal ☐ Yes ☐ No Frequent nose bleeds ☐ Yes ☐ No

Number of Strep throat infections per year _____

Mononucleosis ☐ Yes ☐ No Date _____

Eyes/vision Normal ☐ Yes ☐ No Squints ☐ Yes ☐ No

Glasses ☐ Yes ☐ No Reason? _____

Has problems with his/her eyes? (i.e.: eyes cross/wander) ☐ Yes ☐ No

Explain _____

Do you have concerns about your child's vision (explain) _____

Ears/hearing Normal ☐ Yes ☐ No Frequent ear infections or history of ☐ Yes ☐ No

PE tubes (list date(s)) _____

Hearing loss (Right) ☐ Yes ☐ No (Left) ☐ Yes ☐ No

Hearing aids (Right) ☐ Yes ☐ No (Left) ☐ Yes ☐ No Use sign language ☐ Yes ☐ No

Seen by a specialist for hearing ☐ Yes ☐ No If yes, date_____

REVIEW OF BODY SYSTEMS *(continued)*

Respiratory
Normal ☐ Yes ☐ No
Four or more colds a year ☐ Yes ☐ No
Frequent coughing at night ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Wheeze or cough during exercise ☐ Yes ☐ No
Asthma/reactive airway disease ☐ Yes ☐ No
+ Mantoux test or tuberculosis ☐ Yes ☐ No

Cardiovascular/heart
Normal ☐ Yes ☐ No
Known heart condition or restrictions (describe) _____
Has your child fainted or passed out during or after exercise, emotion or startle? ☐ Yes ☐ No
Has your child had discomfort, pain or pressure in his/her chest during exercise? ☐ Yes ☐ No

Stomach/intestines
Normal ☐ Yes ☐ No
Frequent stomach aches ☐ Yes ☐ No
Frequent diarrhea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Incontinent of stool ☐ Yes ☐ No

Genital/urinary/kidney
Normal ☐ Yes ☐ No
Frequent accidents/day ☐ Yes ☐ No
Has had bladder or kidney problem ☐ Yes ☐ No
Describe bladder or kidney problem _____
Self-catherization ☐ Yes ☐ No Frequency (list) _____

Skeleton/bones
Normal ☐ Yes ☐ No
Pain in joints ☐ Yes ☐ No
Leg/hip/arm/bone etc. problems ☐ Yes ☐ No Describe _____
Has or has had leg/arm braces or corrective shoes ☐ Yes ☐ No Describe _____

Neurological/muscular
Normal ☐ Yes ☐ No
Weakness in his/her body ☐ Yes ☐ No
Loses balance/clumsy ☐ Yes ☐ No
Unexplained movements or jerks ☐ Yes ☐ No
Staring spells ☐ Yes ☐ No
Seizures or history of ☐ Yes ☐ No Type_____ Date of last seizure _____

Endocrine
Diabetes ☐ Yes ☐ No Hepatitis ☐ Yes ☐ No Other _____

Skin
Normal ☐ Yes ☐ No
Bruises easily ☐ Yes ☐ No
Unexplained lumps or spots ☐ Yes ☐ No
Frequent rashes/sores ☐ Yes ☐ No

Dental
Date of last dental appointment_____
Dental/teeth concerns or problems _____

Reproductive Started
Menstrual period ☐ Yes ☐ No
Suffers from menstrual cramps ☐ Yes ☐ No

Are there personal issues the student would like to talk to the school nurse about_____

_____

SOCIAL/EMOTIONAL/MENTAL HEALTH

Has the student ever had any of the following

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Depression			Autism spectrum			Drug use		
Anxiety disorder			Eating disorder			Alcoholism		
Excessive weight (check one) Gain ☐ Loss ☐			Obsessive/compulsive disorder			Bipolar mood disorder		
Suicide (check one) Thoughts ☐ Attempt ☐			Oppositional defiant disorder			Other (describe)		

ADHD/ADD ☐ Yes ☐ No Age diagnosed _____ Diagnosed by _____

Behavior concerns (explain) _____

Family concerns (divorce/separation/illness) _____

DAILY LIVING/HEALTH HABITS

Known lead exposure? ☐ Yes ☐ No

Do you have concerns about your current weight? ☐ Yes ☐ No

Do you have any problems or concerns with eating ☐ Yes ☐ No Describe _____

Are you on a special diet or do you receive any type of special feedings (i.e.: tube feedings) ☐ Yes ☐ No

(Explain) _____

Daily living skills age appropriate (i.e.: dressing, eating, etc.) ☐ Yes ☐ No Describe _____

Any special equipment/assistance needed for daily cares/routines/mobility _____

Cultural/religious needs _____

HEALTH CARE PROVIDERS – Physician/Physician's Assistant/Nurse Practitioner/Dentist

Health Care Provider	Specialty	Clinic Location	Phone

HEALTHCARE PROVIDERS/PHYSICIAN, NURSE PRACTITIONERS/DENTIST *(continued)*

Other outside agencies helping your child. Give names - phone numbers (nursing, personal care providers)

Agency	Contact Person	Service Provided	Phone

HEALTH INSURANCE

Is student covered by medical insurance? ☐ Yes ☐ No

Private insurance ☐ Yes ☐ No Name of Company _____

MN Care ☐ Yes ☐ No

Medical Assistance (MA) ☐ Yes ☐ No

Do you receive SSI or Tefra Benefits ☐ Yes ☐ No

Signature _____ Date _____

Parent/Guardian