

SUDBURY PUBLIC SCHOOLS
Interval Health History

Name _____

Grade _____

Dear Parent/Guardian: This year, in order to keep your child's health record up to date and to provide better health services to your child, we ask that you complete the following form and return it to your school nurse in a separate envelope.

Accidents (explain) _____

Allergies _____

Asthma _____

Bone or Joint Disease _____

Seizure Disorder _____

Diabetes _____

Dental Concerns _____

Ear Infections _____

Throat Infections _____

Frequent Headaches _____

Frequent Stomachaches _____

Heart Disease/Murmur _____

Urinary Tract Concerns _____

Bowel Concerns _____

Menstrual Concerns _____

Hospitalizations _____

Operations _____

Is your child being treated for:

Posture _____

Date _____

Vision _____

Date _____

Hearing _____

Date _____

What medicine, if any, does your child take?

Does your child have any present physical limitations?

Please add any other problems or comments you would like to bring to the attention of the school nurse. Use the reverse side if needed.

Signature _____

Date _____