ENTERING SCHOOL _____

FROM _____

WAYNE TOWNSHIP PUBLIC SCHOOLS

HEALTH HISTORY APPRAISAL

(To be completed by Parent)

GRADE _____

ACADEMIC YEAR _____- _____

Name of Student	Date of Birth	Gender ☐ M ☐ F ☐ X

Yes	No	Please indicate whether the student suffers from any of the conditions listed below:		
☐	☐	**Allergies**	**Type**	**Medication** — Need to be taken in school ☐ Yes ☐ No
☐	☐	**Asthma**	**Triggers**	**Medication** — Need to be taken in school ☐ Yes ☐ No
☐	☐	**Other Medications**	**Type/Dose**	**Purpose** — Need to be taken in school ☐ Yes ☐ No
☐	☐	**Accidents/Injuries**	**Type of Injury**	**Complications** — **Date of Injury**
☐	☐	**Hospitalization**	**Reason**	**Complications** — **Date of Hospitalization**
☐	☐	**Congenital Abnormalities**	**Type**	**Limitations** — **Date of Diagnosis**

Does your child currently have Section 504 Services or an IEP?	Has your child ever been evaluated for Speech or received OT or PT services?
☐ Yes ☐ No	☐ Yes ☐ No

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	ADD/ADHD	☐	☐	Dental Problem	☐	☐	Glasses/Vision	☐	☐	Kidney Disease	☐	☐	Psychiatric Disorder
☐	☐	Autistic Spectrum	☐	☐	Developmental Delay	☐	☐	Hearing Loss	☐	☐	Lead Poisoning	☐	☐	Scoliosis
☐	☐	Behavior Problems	☐	☐	Diabetes	☐	☐	Heart Disease	☐	☐	Lupus	☐	☐	Sickle-Cell Disease
☐	☐	Blood Disorder	☐	☐	Eczema	☐	☐	Heart Murmur	☐	☐	Migraines	☐	☐	Speech Defect
☐	☐	Concussion	☐	☐	Fainting	☐	☐	Hepatitis	☐	☐	Nose Bleeds	☐	☐	Toileting Problem
☐	☐	Convulsive Disorder	☐	☐	Gastric Disorder	☐	☐	Immune Disorder	☐	☐	Orthopedic Disorder	☐	☐	Other _____

Explanation of any "YES" answers above:

Parent/LG Signature: _____ **Date:** _____

Nurse Signature: _____ **Date:** _____