New Student Checklist
School Health Services – Haverhill Health Department

Student Name: _____ DOB: _____

Please answer each of the following questions:

Y N Do you have any concerns with your child's overall health?

Y N Has your child been diagnosed with a chronic disease?
Asthma_____, Diabetes_____, Seizures_____, Other_____

Y N Does your child have any allergies? (Food, Insects, Medication, latex?)
Please specify_____

Y N Does your child need an Epipen?

Y N Does your child take any medications, daily or occasionally?

Y N Will your child need medications in school?
Please explain_____

Y N Does your child need an inhaler?

Y N Does your child have any problems with hearing, vision, or speech?

Y N Has your child had any hospitalizations, operations, major illnesses or injuries, or significant accidents? Please specify _____

Y N Has your child experienced any difficulty with wheezing, excessive coughing, excessive night waking, excessive weight loss or gain, excessive thirst or urination?

Family History

Y N Was pregnancy full term?

Y N Any problems with labor and delivery?
What was your child's birth weight? _____

Y N Family history of Disease?

Parent/Guardian Signature: _____ Date: _____

Office Use Only

____ Immunizations – including lead and varicella
____ Copy of most recent physical, birth certificate
____ Any other medical paperwork (md orders, permissions, etc.)
____ Heath history with nurse by appointment.

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