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Wrentham Public Schools

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Health History

Name: ______________________ Date: ____________

Address: ______________________ City/State/Zip: ____________

Age: ________ Date of Birth: ____________ Place of Birth: ____________

Family Doctor: ______________________ Family Dentist: ____________

If your child has or has ever had, the following, please check the appropriate box.
If the answer is "Yes" please give details: i.e., doctor, date, etc.

		No	Yes	Details
1.	A Heart Condition	☐ No	☐ Yes	
2.	Rheumatic Fever	☐ No	☐ Yes	
3.	Kidney Problems	☐ No	☐ Yes	
4.	Convulsions	☐ No	☐ Yes	
5.	Frequent Ear Infections	☐ No	☐ Yes	
6.	Hearing Difficulties	☐ No	☐ Yes	
7.	Visual Problems	☐ No	☐ Yes	
8.	Glasses	☐ No	☐ Yes	
9.	Epilepsy	☐ No	☐ Yes	
10.	Allergies	☐ No	☐ Yes	
11.	Asthma	☐ No	☐ Yes	
12.	Bone Conditions	☐ No	☐ Yes	
13.	Diabetes or Thyroid	☐ No	☐ Yes	
14.	Operations	☐ No	☐ Yes	
15.	Extended Hospitilizations	☐ No	☐ Yes	
16.	Serious Accident	☐ No	☐ Yes	
17.	Serious Illness	☐ No	☐ Yes	
18.	Fainting	☐ No	☐ Yes	
19.	Severe Nose Bleeds	☐ No	☐ Yes	
20.	Premature Birth	☐ No	☐ Yes	
21.	Frequent Throat Infections	☐ No	☐ Yes	
22.	Treatment or observation for any condition?	☐ No	☐ Yes	
23.	Taking any medication?	☐ No	☐ Yes	

Parent or Guardian Signature: ______________________ **Date:** ____________

Wrentham Public Schools does not discriminate on the basis of race, color, sex, gender identity, religion, national origin, sexual orientation, disability, or homelessness.