

## Student Placement Center Health History Update

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID: \_\_\_\_\_

Health reviewed; No concerns:  Student not present:  Interpreter Used:

Information gathered by: \_\_\_\_\_ from: \_\_\_\_\_

### Illnesses/Injuries:

During the **last 3 years** has your child had *(please describe below)*:

- Serious/Illness/Injury: \_\_\_\_\_  
\_\_\_\_\_
- Hospitalizations/Emergency Department visits: \_\_\_\_\_  
\_\_\_\_\_
- Surgery: \_\_\_\_\_
- Has seen a medical specialist: \_\_\_\_\_

### Have you ever been told by a health care provider that your child has/had:

Asthma:  Depression:  Anxiety:  Seizures:  Diabetes:

ADHD (*Attention Deficit Hyperactivity Disorder*):  Hearing concern:  Vision concern:

Chicken pox:  Other:  *(please specify)* \_\_\_\_\_

### Current Health:

Medications your child takes: *(please specify)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was your child born or ever travelled outside the United States for 3 months or more: No  Yes

If Yes, please check if your child currently has any of the following symptoms:

Night sweats:  Unexplained weight loss:  Cough:  Fever:

Does your child have allergies to?

- Food:  *(please specify)* \_\_\_\_\_  
\_\_\_\_\_
- Insect Stings:  *(please specify)* \_\_\_\_\_

Does your child have an EpiPen:  *(please specify)* \_\_\_\_\_

Is this student: Pregnant:  Due Date: \_\_\_\_\_ Parenting:  Date: \_\_\_\_\_