Alan Shawn Feinstein Middle School of Coventry School
Health History

Dear Parents: Please complete the following forms for your middle school student. This information will be treated as confidential, and may be returned in a sealed envelope to the middle school nurse. This updated information will assist the nurse in addressing the changing health needs of your child.

Name________________DOB_____Sex__GR____Team__________

Please check, list, explain and/or date all that apply:

- ☐ Allergies: _______________
- ☐ Asthma: ________________
- ☐ Attention Difficulties: _____
- ☐ Diabetes: ___Type_1 ☐ 2 ☐
- ☐ Lyme Disease: ____________
- ☐ Mononucleosis: ___________
- ☐ Strep. Throat: ___________
- ☐ MRSA Infection: _________
- ☐ Headaches: ______________
- ☐ Migraines: ______________
- ☐ Seizures: _______________
- ☐ Anxiety: ________________
- ☐ Depression: _____________
- ☐ Substance Abuse: _________
- ☐ Anger Issues: ____________
- ☐ Eating Disorder: _________
- ☐ Other Mental Health Issues: ______________________
- ☐ Gastrointestinal: __________ ______________________
- ☐ Ulcers: _________________
- ☐ Weight Problems: ________
- ☐ Menstrual Problems: _______
- ☐ Heart Disease:___________
- ☐ Urinary Tract Infections: ___
- ☐ Kidney Problems:__________
- ☐ Musculoskeletal: _________ ____________________
- ☐ Pain: ___________________
- ☐ Medications:_____________ ______________________ ______________________
- ☐ Hospitalizations: __________ ______________________ ______________________
- ☐ Injuries: _______________ ______________________ ____________________
- ☐ Other concerns:_________ ____________________ ____________________ ____________________

Doctors Names:

____

____

Parents please complete both sides of this form.

Parent Signature: _____________________________ Date: ________