

**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?

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**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: \_\_\_\_\_