Nimiipuu Health Medical History Form (Child)

Patient's Name LAST FIRST MIDDLE INITIAL	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	Patient's Grade Level
Phone Home Work		Sex M F

Have you (the parent/guardian) or the patient had any of the following diseases or problems?..... Y N
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

Anemia ……..Y N Cancer……..Y N Ear Aches……..Y N HIV/AIDS……Y N Mononucleosis……..Y N Thyroid…..Y N
Cerebral Palsy…..Y N Fainting……Y N Immunizations……Y N Mumps……Y N Tobacco/Drug Use…Y N Asthma…..Y N
Growth Problems..Y N Kidney……..Y N Pregnancy (teens)..Y N Tuberculosis..Y N Bladder……...Y N Sickle cell..Y N
Hearing…….. Y N Chicken Pox……Y N Hepatitis……Y N Arthritis……...Y N Chronic Sinusitis……Y N Measles…Y N
Latex allergy……..Y N Rheumatic Fever.Y N Bleeding disorders.Y N Diabetes…….Y N Heart……Y N Sexually Transmitted Infection..Y N
Liver……Y N Seizures……Y N Bones/Joints……Y N Other_____

Please list the name and phone number of the child's medical provider:

Name of Provider_____Phone _____

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... Y N

If yes, please list:_____

Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ Y N

Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ Y N

Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ Y N

Has the child ever been hospitalized? If yes, when: _____ Please describe: _____ Y N

Does the child have a history of any other illnesses? If yes, please list: _____ Y N

Is the child physically, mentally, or emotionally impaired?..... Y N

Does the child experience excessive bleeding when cut?..... Y N

Has the child had any problem with dental treatment in the past? ..... Y N

Has the child ever suffered any injuries to the mouth, head or teeth? ..... Y N

Please provide Immunizations as needed for my child? ..... Y N

The answers I have given are true to the best of my knowledge. I am indicating consent for routine procedures such as; [ ] **immunizations [ ],sports physicals[ ], Optical [ ], x-rays [ ], fluoride [ ], fillings [ ], and simple extractions of primary teeth[ ]**. Dental anesthetic (topical or local) is commonly used to provide comfort during dental care. It is safe but has certain risks. Common risks are bruising, swelling, or pain at the site of the injection. A temporary rapid heartbeat sometimes occurs. Permanent numbness or abnormal sensations rarely occur. I consent to the use of anesthetic for dental care.

Parent's/Guardian's Signature_____Date_____

Provider's Signature_____Date_____

☐ **Yes, I approve National Guard medical services May12-21, 2026 _____ Date:_____**