



## STUDENT HEALTH HISTORY

This information is important for the health and safety of your child while at school. Please provide all of the information requested below.

Child's Name \_\_\_\_\_

Child's Address \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_ School \_\_\_\_\_

**Please**  **all applicable issues**

- Allergies (specify) \_\_\_\_\_
- Anemia (Sickle Cell or Other) \_\_\_\_\_
- Asthma or bronchitis have motor skills problems \_\_\_\_\_
- Bowel problems \_\_\_\_\_
- Chicken Pox Disease \_\_\_\_\_
- Chronic skin condition \_\_\_\_\_
- Convulsions/seizures \_\_\_\_\_
- Dental problems \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Ear infections \_\_\_\_\_
- Eating disorder \_\_\_\_\_
- Emotional/psychiatric problem \_\_\_\_\_
- Fluoride Supplement \_\_\_\_\_
- Food Supplement \_\_\_\_\_
- Frequent colds/sore throat \_\_\_\_\_
- Frequent headaches \_\_\_\_\_
- Frequent stomach aches \_\_\_\_\_
- Heart problem \_\_\_\_\_
- Modified Diet \_\_\_\_\_
- Motor Skill Issue \_\_\_\_\_
- Operations (specify, give dates) \_\_\_\_\_
- Premature Birth \_\_\_\_\_
- Serious accident, injury (*specify, give date*): \_\_\_\_\_
- Serious Illnesses (*specify, give date*): \_\_\_\_\_
- Speech/communication problem \_\_\_\_\_
- Substance abuse (alcohol, drugs) \_\_\_\_\_
- Other problems or handicapping conditions (specify) \_\_\_\_\_

Does your child:

Use corrective lenses (i.e. contacts)?  yes  no

Wear glasses?  yes  no

Use a hearing aid?  yes  no

**Explain any condition checked:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Regular medications taken (specify): \_\_\_\_\_

List any other concern you have about your child's health, development, learning behavior or home situation which might affect student's performance: \_\_\_\_\_

Other information regarding your child: \_\_\_\_\_

**Note: There are immunizations required by state law and a tuberculosis risk assessment that must be completed prior to enrollment.**

Name of Doctor, Hospital, or Clinic: \_\_\_\_\_ Phone \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Phone \_\_\_\_\_

Date Form Completed: \_\_\_\_\_