



# Student Health History

(to be completed by parent)

Student's Name \_\_\_\_\_

Sex \_\_\_\_\_

Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_

Does student have any medical condition that the staff should be alerted to?  yes  no

If yes, please describe \_\_\_\_\_

List daily medication(s) and/or treatment(s): \_\_\_\_\_

Will child require medication/treatments during school?  yes  no

If yes, a consent form is required!

Has student had any of the following? (Give year if possible)

Chicken Pox \_\_\_\_\_  
Scarlet Fever \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Hay Fever \_\_\_\_\_  
Hepatitis \_\_\_\_\_  
Nosebleeds \_\_\_\_\_

Asthma \_\_\_\_\_  
Hives \_\_\_\_\_  
Mumps \_\_\_\_\_  
Eczema \_\_\_\_\_  
Headaches \_\_\_\_\_

German Measles \_\_\_\_\_  
Regular Measles \_\_\_\_\_  
Bee Sting Allergy \_\_\_\_\_  
Rheumatic Fever \_\_\_\_\_  
Stomach Disorder \_\_\_\_\_

Frequent Colds, Sore Throats \_\_\_\_\_

Seizures (Explain) \_\_\_\_\_

Other (Explain) \_\_\_\_\_

Hospitalizations, injuries or serious illness (Explain and give year or age) \_\_\_\_\_

Ear infections? \_\_\_\_\_

Which ear? \_\_\_\_\_

Any hearing difficulty? \_\_\_\_\_

Vision difficulty? \_\_\_\_\_

Wears glasses? \_\_\_\_\_

Date of last exam \_\_\_\_\_

Any speech difficulty? \_\_\_\_\_

Does your student have allergies to animals, insects, food or plants that we should be aware of?

Are there any other physical, developmental or emotional conditions that the school needs to be aware of? If so, please explain.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_