HEALTH HISTORY INFORMATION

GRADE	HOMEROOM / TEACHER

NAME OF STUDENT		☐ FEMALE ☐ MALE	DATE OF BIRTH
MOTHER / GUARDIAN NAME	PHONE	FATHER / GUARDIAN NAME	PHONE

Has your child had any of the following: Give details (use back of page if necessary)

A. Allergies ____________________
B. Recurring illness ____________________
C. Operations (type) ____________________
D. Vision problems ____________________
E. Bladder problems ____________________
F. Seizures ____________________
G. Asthma ____________________
H. Diabetes ____________________
I. Emotional problems ____________________
J. Serious accidents ____________________
K. Hearing problems ____________________
L. Stomach upsets ____________________
M. Headaches ____________________
N. Other ____________________

Check and **give dates** if your child had any of the following: (Note any complications)

- ☐ Chickenpox ____________________
- ☐ Infectious hepatitis ____________________
- ☐ Pneumonia ____________________
- ☐ Rheumatic fever ____________________
- ☐ Scarlet fever ____________________
- ☐ Scoliosis ____________________
- ☐ Tuberculosis ____________________(self or family)
- ☐ Any surgery (year) ____________________
- ☐ Any hospitalizations (year) ____________________

Is your child presently under medical treatment? Yes____ No____

If so, give details ____________________

Is your child presently taking medication? Yes____ No____

If so, give details including name of medication ____________________

List any illness or health problems, which you or your family physician feels, should be known to the school authorities:

____

Date of last physical exam ____________________ Physician's Name ____________________

Date of last dental exam ____________________ Dentist's Name ____________________

THE SCHOOL NURSE MAY SHARE THIS INFORMATION WITH APPROPRIATE FACULTY AND STAFF.

PLEASE NOTIFY THE NURSE OF ANY CHANGES IN YOUR CHILD'S HEALTH.

PARENT/GUARDIAN SIGNATURE ____________________ **DATE** ____________________