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** and use back of page, if necessary.

A. Allergies ☐ Yes ☐ No If yes, check the appropriate type below and in the blank describe the allergy, the reaction, and the treatment.

My child is allergic to: ☐ Medicine: _____ ☐ Food: _____

☐ Pollen: _____ ☐ Stinging Insect: _____

☐ Other: _____

Has your child ever required an EpiPen: -☐ Yes ☐ No. If yes, List the reason and last use date: _____

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 yes, give details: _____

Is your child presently taking medication? -☐ Yes ☐ No. If yes, 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 _____ Phone _____

Date of last dental exam _____ Dentist's Name _____ Phone _____

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**