

STUDENT HEALTH HISTORY

To be completed by Parent/Guardian each school year



Student's Name _____ Sex _____ Birthdate _____ Grade _____

This information is requested in order to provide appropriate health services for your student. It will be treated as private data and recorded in the student health record. It will be shared with those working with your student on a "need to know" basis and with emergency personnel in case of an emergency.

Does your student have any chronic health conditions? (check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Asthma: <input type="checkbox"/> needs daily meds at school; |
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> <input type="checkbox"/> exercise induced; <input type="checkbox"/> seasonal related to allergy |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Food, List: _____ | <input type="checkbox"/> Behavior Concerns |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Bleeding, Blood disorder |
| <input type="checkbox"/> Seasonal | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Concerns |
| | <input type="checkbox"/> Headaches |
| | <input type="checkbox"/> Heart Condition |
| | <input type="checkbox"/> Hearing Impairment |
| | <input type="checkbox"/> Neurological |
| | <input type="checkbox"/> Orthopedic - Scoliosis |
| | <input type="checkbox"/> Seizure Disorders |
| | <input type="checkbox"/> Vision Loss |
| | <input type="checkbox"/> Other _____ |

Explain _____

Has your student been hospitalized or treated in the emergency room for any of the above conditions in last year? Yes _____ No _____

If yes, explain _____

Is your student's physical activity limited in any way? Yes _____ No _____

If yes, explain _____

Does your student take any medications Yes _____ No _____

(All medications at school must be administered within school procedure guidelines.)

<u>Name of Medication</u>	<u>Frequency</u>	<u>For treatment of:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations given within the last year:

_____	_____	_____
TYPE	Month/Day/Year	TYPE Month/Day/Year

Parent/Guardian Signature _____
Home Phone _____

Date _____
Work Phone _____

Doctor or Clinic Name _____
10/8/2002 lk

Clinic Phone _____

