HEALTH HISTORY FORM (To be completed by parent or guardian)

Directions: Please complete the following information and return it to the school office (Please Print)

GENERAL INFORMATION:

Student's Name____________________ Date of Birth____________

Address:______________________________ Phone Number__________

SIGNIFICANT HEALTH HISTORY (If you check an item, please indicate the year the incident, difficulty, disease was first diagnosed. (please give a brief explanation)

Asthma ____________________ Diabetes____________________

Excessive Colds____________________ Frequent Ear Infections____________________

Birth Defect____________________ Heart Disease____________________

Bone, Joint, Muscle Problems____________________ Seizure Disorder____________________

Speech Problems____________________

ALLERGIES (Please check what applies to your child. Give a brief explanation)

Medications____

Bee Sting Requiring Treatment____

Food____

Other____

KNOWN EYE AND HEARING PROBLEMS

Glasses__________________ Contact Lenses__________________ Preferential Seating__________________

Hearing Aid_______________

OTHER INFORMATION

Date of Last Physical Exam____________________ Date of Last Dental Exam______________________________

Is your child taking any medications, if so please explain____

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Is there any other information regarding the health of your child that you feel would be important for the school to know

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