HEALTH HISTORY

The school district considers this to be personal, confidential information that will be treated in a discreet manner. The form may be reviewed by the school nurse, the classroom teacher, the building administrator, and other educators on a need to know basis.

Today's Date ____________________

Name ____ Date of Birth ____________________
(last) (first) (middle)

School ____________________ Teacher ____________________ Grade ________

Physician ____________________ Dentist ____________________

Please fill in any information that is applicable, Please use the back side if necessary for additional information

1) Asthma medications ____________ symptoms ____________
2) Allergy specify ____________ symptoms ____________
3) Diabetes insulin/snacks ____________ symptoms ____________ age of onset ______
4) Seizures medications ____________ symptoms ____________ age of onset ______
5) ADD/ADHD ____________ medications ____________
6) Visual problems ____________ glasses/contacts ____________
7) Hearing problems ____________ frequent ear infection ____________ hearing aids ____________
8) Heart conditions ____________ specify restrictions ____________
9) Congenital/Chronic conditions ____________
10) Chicken Pox (date) ____________
11) Serious injuries (list) ____________
12) Operations (list) ____________

13) Other ____________

14) Special seating, bathroom privileges, restrictions ____________

15) Please list medications your student takes both at home and school. **MEDICATIONS GIVEN AT SCHOOL MUST BE CHECKED INTO THE OFFICE.**

16) Immunizations administered within the past year: ____________
(Please provide documentation)

____________________ Individual Completing Form

____________________ Relationship to Student

____________________ Home Phone

____________________ Work Phone