

STUDENT HEALTH HISTORY

Student Name: _____ Birthdate: _____

School: _____ Grade Entering: _____ Today's Date: _____

The following information is considered confidential and is only for use by the school nurse, health clerk, teachers, principal, or other staff who will be in contact with and responsible for your child during the school day.

Physician: _____ Date of last physical: _____

Dentist: _____ Date of last exam: _____

Check any of these conditions your child has:

Condition	Pertinent Information
Allergy** ___ Mild ___ Severe	To what?
	Medication/Treatment:
Asthma** ___ Mild ___ Severe	Triggers?
	Medication/Treatment:
ADD / ADHD	Medication/Treatment:
Bladder/Bowel	
Blood Disorders	
Cancer	
Congenital Disorders	
Dental	
Diabetes**	Medication/Treatment:
Fainting	
Headaches	
Hearing Loss	Which ear? Hearing aid?
Heart	Medication/Restrictions:
Hypoglycemia	Treatment:
Muscular/Orthopedic	Describe/Limitations:
Nose Bleeds	Frequency & Severity:
Seizure/Epilepsy**	Medication:
Skin Conditions	
Social/Emotional/Behavioral	
Speech	
Vision	Glasses or Contacts:
	To be worn: ___ All the time ___ For Distance ___ For Reading
Other	
Takes medication daily	Specify:
Medication at school*	Specify:

*Students receiving any medication at school must have a current, signed "Medication Authorization & Consent Form" on file in the Health Office –Forms available in the school office.

**Students with severe or chronic conditions should have a current, signed "Action Plan" on file in the Health Office - Forms available in the school office.

I understand the above information will be shared with school staff members.

Parent/Guardian Signature: _____ Date: _____