



S I N C E 1 8 7 1

Dear Parent or Guardian:

HEALTH HISTORY - CONFIDENTIAL

Please fill out this health history form as completely as you can so that the school will have all of the necessary information to safe-guard your child's health and well being during the school hours.

Thank you.

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M F Grade: \_\_\_\_\_
Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_
Doctor's Name: \_\_\_\_\_ Doctor Phone: \_\_\_\_\_

HEALTH CONDITIONS: which school should be aware of:

Please circle: Yes or No Comment Comment
Asthma: Yes No \_\_\_\_\_ Ear Infections: Yes No \_\_\_\_\_
Seizures: Yes No \_\_\_\_\_ Headaches: Yes No \_\_\_\_\_
Eczema: Yes No \_\_\_\_\_ Bones/Joint pain: Yes No \_\_\_\_\_
Vision: Yes No \_\_\_\_\_ Hearing Problems: Yes No \_\_\_\_\_
Scoliosis: Yes No \_\_\_\_\_ Hypoglycemia: Yes No \_\_\_\_\_
Fainting: Yes No \_\_\_\_\_ Diabetes: Yes No \_\_\_\_\_
Family history of: \_\_\_\_\_

Chronic Conditions: Yes No \_\_\_\_\_
Heart Conditions: Yes No \_\_\_\_\_
Physical Disability: Yes No \_\_\_\_\_

Injuries: \_\_\_\_\_
Hospitalizations/Surgeries: \_\_\_\_\_

Other Health Concerns: \_\_\_\_\_

ALLERGIES: Yes No If "Yes", specify what the allergy is and describe what happens to your child.

ILLNESSES: Please date when: Chicken Pox: (Month) \_\_\_\_\_ (Year) \_\_\_\_\_
Strep Throat: \_\_\_\_\_ Fractures: \_\_\_\_\_
Pneumonia: \_\_\_\_\_ Bronchitis: \_\_\_\_\_ Other: \_\_\_\_\_

Medications your child takes on a regular basis at home or school. Names and Reasons: \_\_\_\_\_

Emotional Concerns: \_\_\_\_\_

Development Delay: Yes No \_\_\_\_\_
Learning Difficulties: Yes No \_\_\_\_\_
Learning Disabilities: Yes No \_\_\_\_\_
Speech Difficulties: Yes No \_\_\_\_\_

ABILITY TO PARTICIPATE FULLY IN ALL PHYSICAL ACTIVITIES? Yes No If "No", please explain:

PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_