



SINCE 1871

STUDENT HEALTH HISTORY
2011-2012

CONFIDENTIAL

Dear Parent or Guardian:

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:

Table with 4 columns: Condition, Yes, No, Comment. Rows include Asthma, Seizures, Eczema, Vision, Scoliosis, Fainting, Ear Infections, Headaches, Bones/Joint pain, Hearing Problems, Hypoglycemia, Diabetes.

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: