

**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 \_\_\_\_\_

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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