STUDENT HEALTH HISTORY

To be completed by parent or guardian

20____-20_____

STUDENT'S NAME: _____ GRADE: _____SCHOOL:_____

SEX: MALE FEMALE BIRTHDATE: _____PHONE #_____

DOCTOR'S NAME: _____

<u>*IF YOU INDICATE YES FOR ANY CATEGORY, PLEASE EXPLAIN***</u>**

ALLERGIES **YES NO _____**

USES EPIPEN **YES NO _____**

ASTHMA **YES NO _____**

HAS INHALER **YES NO _____**

FREQUENCY OF USE **RARELY ONCE DAILY >ONCE DAILY WITH SPORTS**

REQUIRES INHALER AT SCHOOL **YES NO _____**

BLOOD DISORDERS **YES NO _____**

DAILY MEDICATIONS **YES NO _____**

NAMES OF MEDICATIONS **_____**

Include those taken at home. If taken at school, the medication authorization form must be completed and on file.

DIABETES **YES NO _____**

EAR/HEARING PROBLEMS **YES NO _____**

GLASSES/CONTACTS (CIRCLE ONE) **LAST EYE EXAM _____**

EYE/VISION PROBLEMS **YES NO _____**

HEART PROBLEMS **YES NO _____**

HOSPITALIZATIONS **YES NO _____ AGE: _____**

MENTAL HEALTH CONCERNS **YES NO _____**

NEUROLOGICAL PROBLEMS **YES NO _____**

PHYSICAL RESTRICTIONS **YES NO _____**

SEIZURES **YES NO _____**

SERIOUS INJURIES **YES NO _____AGE: _____**

SURGERY **YES NO _____AGE:_____**

OTHER **YES NO _____**

I release this information to be shared with appropriate personnel for health and educational purposes.

_____ _____

Parent/Guardian Signature **Date**

Please contact the nurse if you would like to discuss any medical concerns, *(insert health office phone #)*

Updated 11/01/10