

Signature of Parent/Guardian

STUDENT HEALTH HISTORY

PLEASE UNDERSTAND THAT BY FILLING OUT THIS INFORMATION IT MAY BE SHARED WITH THE APPROPRIATE SCHOOL AND MEDICAL PERSONNEL.

Student Name:			Date of Birth:			
Last The following information may be to speak personally with your scho	First nelpful in assessing a child's health/le ol nurse.	Middle earning. If you do not wis	h to compl	ete the entire form, you r	nay wish	
DOES YOUR CHILD HAVE OR HAD A Allergic to Food Allergic to Meds Allergies/Seasonal Asthma Mild Moderate Se Attention Deficit Disorder/Al Anxiety Bleeding Disorders** Cerebral Palsy	Chicken Pox: Ag Diabetes** Depression Seizure Disorder/ Scoliosis	'Epilepsy**	High Kidn Osgo Irrita Celio	rt Problems I Blood Pressure ey Disorder ood Schlatter's ble Bowel Syndrome ac Disease uent UTIs (diagnosed by	Doctor)	
**THESE STUDENTS MUST HAVE A <u>CU</u>	<u>JRRENT</u> TREATMENT PLAN ON FILE IN TI	HE HEALTH OFFICE. **				
HAS YOUR CHILD EVER HAD: Surgery Psychological Exam Been in special classes Hearing Problems Tubes in ears Hearing Aids S YOUR CHILD CURRENTLY TAKING	Or have any fo	ent/injury ns		(Must have note from Do	octor)	
MEDICATIONS	DOSE LIST ALL BELOW	FREQUENCY		REASON		
PLEASE EXPLAIN ALL ABOVE MARKE	ED ANSWERS:					
Prenatal History: Toxemia: Yes No Diabet Length of Pregnancy:r No	PFUL TO HAVE IN CASE YOUR CHILD N tes:			CIAL SERVICES: uries during pregnancy:	□Yes □	
Birth History: Birth weight: lbs oz. No	Needed oxygen? □Yes	; □No Jo	aundice? [Yes □No Seizures?	□Yes □	
At what age did this child: Roll over: Sit up: Speak in 2- or 3-word sentences: Is this child's speech difficult to unc	Daytime bladd	der control:		httime bladder control: _		
PLEASE CONTACT YOUR SCHOOL'S	S NURSE TO DISCUSS YOUR CHILD'S M	IEDICAL CONCERNS.				

Date