Student Health History

School Name: _____

Student Name: _____ _____ Sex: ___ DOB: _____ GR: _____ Homeroom: _____
(Last) (First)

Health Status: Please check any health problems your child has now or has had in the past. Give dates, treatment and current status under explanation.

Allergies: List and describe reactions

Drug Allergies _____ Food Allergies: _____
Seasonal Allergies: _____ Insects: _____
Tape/Bandages: _____ Other Allergies _____

Has your child ever been hospitalized for an allergic reaction? (Explain) Yes ___ No ___
Is an Epinephrine pen (Epi-Pen) prescribed?_____Yes _____No

Has your child ever had any of the following? (Please mark and explain below):

___ Anemia
___ Asthma /Breathing Problems
___ ADHD
___ Bed Wetting
___ Bleeding/Clotting Disorder
___ Bronchitis
___ Cancer/Tumor
___ Chicken Pox
___ Chronic Otitis Media
___ Constipation
___ Dental Problems
___ Depression
___ Diabetes
___ Digestion Prob.
___ Disabilities/Handicaps
___ Eating Disorder
___ Fainting spells
___ Fears/Phobias
___ Heart Murmur
___ Heart Problems
___ Hemophilia
___ High Blood Pressure
___ Immunosuppressed Condition
___ Juvenile Arthritis
___ Kidney/Urinary Problems
___ Leaking/Loss of Urine
___ Liver Disease
___ Migraines/Headaches
___ Mononucleosis
___ Muscle Weakness
___ Nosebleeds
___ Orthopedic Problems
___ Posture Problems
___ Rheumatic Fever
___ Sinus Problems
___ Sleep Disturbances
___ Seizures/Convulsions
___ Skin Problems
___ Speech/Language Prob.
___ Tuberculosis
___ Ulcers
___ Vision Problems
___ Wears Glasses
___ Wears Contacts

Explanations: _____

Is there any tendency in your family toward a specific health problem? _____
Dietary Restrictions: _____
Emotional of behavioral Concerns: _____
Learning Problems: _____
Operations, serious injury or other hospitalizations: Type and Date: _____

Medications (Include routine daily medications your child takes at home and at school- name of, dosage and times

Can your child participate fully in school activities including PE? _____
Special Considerations: _____

If special considerations, medications, treatments or potential risk problems are an indication for your child in school, the school nurse or designated health room personnel will contact you to discuss a plan of care.

Has your child had a comprehensive physical exam in the last two year? (Sports physical or illness visits are not comprehensive exams)
Yes _____ No _____ Date _____

Has your child had a comprehensive dental exam in the last year? Yes ___ No ___
Your child's type of insurance coverage: Private/PPO: ___ HMO: ___ MC+Kids or Medicaid ___
No Insurance _____ Unsure _____
Does your child have a primary health care provider? Examples: Pediatrician, nurse practitioner, family practice physician etc. Do not list the names.) Yes ___ No ___

Is your child covered by dental insurance? Yes ___ No ___ Does your child have a dentist? (Do not list the name) Yes ___ No ___

Signature Parent/Guardian _____ **Date:** _____