HEALTH HISTORY

Helena Public Schools
...a great place to learn

The school district considers this to be personal, confidential information that will be treated in a discreet manner. The form may be reviewed by the school nurse, the classroom teacher, the building administrator, and other educators on a need to know basis.

Today's Date _____

Name _____ Date of Birth _____
(last) (first) (middle)

School _____ Teacher _____ Grade _____

Physician _____ Dentist _____

Please fill in any information that is applicable, Please use the back side if necessary for additional information

1) Asthma medications _____ symptoms _____
2) Allergy specify _____ symptoms _____
3) Diabetes insulin/snacks _____ symptoms _____ age of onset _____
4) Seizures medications _____ symptoms _____ age of onset _____
5) ADD/ADHD _____ medications _____
6) Visual problems _____ glasses/contacts _____
7) Hearing problems _____ frequent ear infection _____ hearing aids _____
8) Heart conditions _____ specify restrictions _____
9) Congenital/Chronic conditions _____
10) Chicken Pox (date) _____
11) Serious injuries (list) _____
12) Operations (list) _____
13) Other _____
14) Special seating, bathroom privileges, restrictions _____
15) Please list medications your student takes both at home and school. **MEDICATIONS GIVEN AT SCHOOL MUST BE CHECKED INTO THE OFFICE.**
16) Immunizations administered within the past year: _____
(Please provide documentation)

_____ _____
Individual Completing Form Relationship to Student

_____
Home Phone

_____
Work Phone