



HEALTH HISTORY

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 _____