

Health History

School Year _____

Name		Date of Birth	
Gender	School	Grade/Teacher	
Physician		Dentist	

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.

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTH CARE PROVIDER WITH ANY OF THE FOLLOWING:

Health Condition	Yes	No	Explanation if "Yes"
Allergies Bee Stings <input type="checkbox"/> Food Allergies <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child require an EpiPen? Yes <input type="checkbox"/> No <input type="checkbox"/> List: EpiPen? Yes <input type="checkbox"/> No <input type="checkbox"/> List: EpiPen? Yes <input type="checkbox"/> No <input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Medication:
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Asthma medication taken at home: Medication required at school:
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Describe: Verbal <input type="checkbox"/> Non Verbal <input type="checkbox"/> Medications:
Bowel/Bladder Issues	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 (insulin dependent) <input type="checkbox"/> Type 2 <input type="checkbox"/> Diabetes medications:
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Hearing Aids <input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Describe:
Mental Health/Emotional/Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	Describe: Medication/Treatment:
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Type of Seizure: Medications:
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	Describe: Dates:
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Describe: Dates:
Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> For Distance <input type="checkbox"/> For Reading <input type="checkbox"/>

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