HEALTH HISTORY

Directions: Please complete the following information and return it to the school office. (Please Print)

GENERAL INFORMATION

Student's Name: _____ Date of Birth: _____ Male ☐ Female ☐
Last First M.I.

Address: _____ Phone Number: _____
Street City State Zip

Parent #1: _____ Parent #2: _____
Last First Last First

SIGNIFICANT HEALTH HISTORY

If you check an item, please indicate the year the incident, difficulty and disease was first diagnosed. If requested, please explain.

YES ☐ NO ☐ Asthma Year: _____ Explain: _____
YES ☐ NO ☐ Birth Defect Year: _____ Explain: _____
YES ☐ NO ☐ Bone, Joint, etc. Year: _____ Explain: _____
YES ☐ NO ☐ Chicken Pox Year: _____ Explain: _____
YES ☐ NO ☐ Diabetes Year: _____ Explain: _____
YES ☐ NO ☐ Excessive Colds Year: _____ Explain: _____
YES ☐ NO ☐ Frequent Ear Inf. Year: _____ Explain: _____
YES ☐ NO ☐ Heart Disease Year: _____ Explain: _____
YES ☐ NO ☐ Hepatitis Year: _____ Explain: _____
YES ☐ NO ☐ Measles/Mumps Year: _____ Explain: _____
YES ☐ NO ☐ Mono Year: _____ Explain: _____
YES ☐ NO ☐ Other Year: _____ Explain: _____

ALLERGIES

Please check all that applies to your child. Give a brief explination where requested.

YES ☐ NO ☐ Medications Explain: _____
YES ☐ NO ☐ Other Explain: _____
YES ☐ NO ☐ Bee Sting Explain: _____
YES ☐ NO ☐ Food Explain: _____

EYE & HEARING HEALTH

YES ☐ NO ☐ Glasses
YES ☐ NO ☐ Contact Lenses
YES ☐ NO ☐ Preferential Seating
YES ☐ NO ☐ Eye Care Under current medical care.
YES ☐ NO ☐ Hearing Aid
YES ☐ NO ☐ Preferential Seating
YES ☐ NO ☐ Hearing Under current medical care.

Date of last physical examination: _____ Date of last dental examination: _____