STUDENT HEALTH HISTORY

Student Name: ______________________ Age: ________ Birthdate: ____________

Parent/Guardian Name(s): ____

Address: ______________________________ Phone Number: ________________

History:

Were there any issues during pregnancy, labor and/or delivery for this child? ❑ Yes ❑ No
If yes, please describe: ____

Does this child have an ongoing health concern? (asthma, diabetes, etc.) ❑ Yes ❑ No
If "yes", please describe: ____

Does this child have any allergies? ❑ Yes ❑ No
If "yes", please list: ____
Has the allergy required emergency treatment? ❑ Yes ❑ No
If "yes", please explain: ____

Does this child have asthma? ___ Yes ____ No
If "yes", please explain: ____

Does this child have a history of convulsions? ___ Yes ___No
If "yes", please explain: ____

Does this child have any problems with hearing? ___ Yes ____ No
If "yes", please explain:____

Does this child have any problems with vision? ___ Yes ____ No
If "yes", please explain____

Are the child's immunizations up to date? ❑ Yes ❑ No
Please attach a current record of immunization.

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No
If "yes", please describe: ____

Are there any current medical concerns/injuries? ❑ Yes ❑ No
❑ Head ______________________ ❑ Eyes ___________ ❑ Nose ___________
❑ Ears ______________________ ❑ Throat __________ ❑ Neck ___________
❑ Chest _____________________ ❑ Respiratory ______________________
❑ Cardiovascular _____________ ❑ Gastrointestinal ___________________
❑ Genitourinary ______________ ❑ Neurological ______________________
❑ Muscloskeletal (include any past fractures, etc.) ______________________

Does this child take any medication regularly at home? ❑ Yes ❑ No
If "yes", please describe: ____

Please list any additional concerns or information: ___________________________

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