Health History

The information requested on this form will be of help to the school personnel in determining the health status of your child and in assisting him/her in receiving maximum benefits from his/her educational opportunity.

Student's Full Name _____
First Middle Last

Complete Address_____

Phone Number _____

Birth Date _____

Place of Birth _____

Name of Parents/Guardian:

Father _____
First Middle Last

Mother_____
First Middle Last

Mother's Maiden Name _____

With whom does the child live? _____

Name of Child's Physician_____Phone Number_____

Family Dentist_____Phone Number_____

Please list other persons living in the household:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Normal pregnancy: yes or no Normal birth: yes or no Birth weight:_____

If no, please explain (optional) such as breech birth, needed oxygen, premature_____

_____

_____

_____

PLEASE COMPLETE OTHER SIDE

Medical History

Please circle YES or NO to the following. If yes, list dates and write a brief comment.

Accidents, serious	Yes	No	_____
Allergy	Yes	No	_____
Asthma	Yes	No	_____
Attention Deficit	Yes	No	_____
Bronchitis	Yes	No	_____
Chicken Pox Disease	Yes	No	_____
Chicken Pox Vaccine (Varicella)	Yes	No	_____
Convulsions	Yes	No	_____
Dental Problems	Yes	No	_____
Diabetes	Yes	No	_____
Ear Tubes	Yes	No	_____
Epilepsy	Yes	No	_____
Fractures	Yes	No	_____
Frequent Earaches	Yes	No	_____
Frequent Nosebleeds	Yes	No	_____
Frequent Sorethroats	Yes	No	_____
Frequent Urination	Yes	No	_____
Glasses / Contacts	Yes	No	_____
Heart Condition	Yes	No	_____
Hemophilia	Yes	No	_____
High Fevers	Yes	No	_____
Hospitalizations	Yes	No	_____
Illness, serious	Yes	No	_____
Immune Deficiency	Yes	No	_____
Pneumonia	Yes	No	_____
Rhematic Fever	Yes	No	_____
Scarlet Fever	Yes	No	_____
Sleep disturbances	Yes	No	_____
Stomachaches	Yes	No	_____
Strabismus (Cross Eyes)	Yes	No	_____
Tuberculosis	Yes	No	_____
Other			_____

Is your child under care for any chronic condition at this time? _____
If yes, state condition _____

Please indicate below any information that you feel will help us to better understand your child _____

_____

_____

Do you want the child's teacher made aware of any special condition that might affect his/her learning experience? Yes or No

_____ _____

Signature of Parent/Guardian Date