



Health History for School Year 20 ____ -20 ____

Dear Parent:

When your child enters school, we establish a cumulative health file for him/her to enable us to have a greater understanding of your child's needs. All information will be kept confidential, so please answer every question. Thank you.

PLEASE PRINT NEATLY. Thank you for your cooperation.

Student's Name: _____ Male / Female Age: _____ Grade: _____

Date of Birth: _____ Home Phone Number: _____

Physician: _____ Dr.'s Phone Number: _____ Dr.'s Fax Number: _____

Child lives with (fill in only what applies):

Mother's Name: _____ Father's Name: _____

(Other) Name and Relationship to child: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Directions: Please answer the following questions about the student's medical history. Explain all "yes" responses on the back of this page. Please respond to all questions.

- I. Has your child had or currently have:
 - a. An injury or illness since your last exam y / n / don't know
 - b. A chronic or ongoing illness (such as diabetes or asthma)? y / n / don't know
 - 1. Use an inhaler or other prescription medicine to control asthma? y / n / don't know
 - c. Any prescribed or over the counter medications taken on a regular basis? y / n / don't know
 - d. Surgery, hospitalization or any emergency room visit(s)? y / n / don't know
 - e. Any allergies to medications? y / n / don't know
 - f. Any allergies to bee stings, pollen, latex or foods? y / n / don't know
 - 1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.)
 - 2. Take any medication or Epi pen taken for allergy symptoms? (List on back.)
 - g. Any anemias or blood disorders? y / n / don't know
- 2. Has your child had or currently have any of the following head-related conditions since the last physical:
 - a. Concussion requiring a physician's evaluation? y / n / don't know
 - 1. How often and when? (Answer on, back page,)
 - b. Memory loss or been knocked out? y / n / don't know
 - c. A seizure? y / n / don't know
 - d. Frequent or severe headaches? y / n / don't know
 - 1 - Medication required? (List on back-)
- 3 Has your child had or currently have my of the. following heart-related conditions since the last physical:
 - a. Chest pain? y / n / don't know
 - b. Heart murmur? y / n / don't know
 - c. High blood pressure or elevated cholesterol level? y / n / don't know
 - d. Restriction from sports for heart problems? y / n / don't know