STUDENT NAME:_____DOB:_____

Health History

(Please check appropriate column, note year, and explain where applicable.)

Allergy Types	**Reaction**	**Implications for school**
Bee		
Drugs		
Food		
Latex		
Pollen		
Skin		
Other (i.e. seasonal)		

Other Conditions (check all that apply)		**Year(s)**	**Explain**
Asthma/Reactive Airway	☐		
Bed wetting	☐		
Blood Disorder	☐		
Cancer	☐		
Concussion/Head Trauma	☐		
Diabetes	☐		
Digestive(constipation /Feeding Disorder	☐		
Disease i.e. chickenpox	☐		
Dietary Restrictions	☐		
Emotional Problems	☐		
Genito/urinary Problems	☐		
Hearing Difficulty	☐		
Heart Disease (defects)	☐		
Hospitalizations	☐		
Infections	☐		
Kidney Disease	☐		
Neuro-muscular disorders/prosthesis	☐		
Organs missing or impaired function of paired organs; i.e. kidneys, testes, eyes	☐		
Seizure Disorder	☐		
Skin Disorder	☐		
Speech Impairment	☐		
Surgical Procedures	☐		
Vision Problems(glasses)	☐		
Other (list and explain) Serious illnesses, accident, genetic disorders)	☐		

A. Is the student receiving medication?
Yes☐ No☐
If yes, complete the following:

Medication(s)	Dose	Times	Reason	Date prescribed	Prescribing Physician

B. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?
Yes☐ No☐
If yes, explain_____

_____

_____

C. Does the student require any special procedures and/or treatments?
Yes☐ No☐
If yes, explain_____

_____

D. Is the student currently under treatment for any health conditions?
Yes☐ No☐
If yes, complete the following:

Condition	Physician	Treatment

Parent Signature_____

Date_____