Student Health Information

☐ Male ☐ Female Date of Birth _____/_____/_____ Grade_____

Student Name _____
(Last) (First) (Middle)

Residence _____
(Street) (Town) (State) (Zip Code)

Father's/Legal Guardian's Name_____ Home Phone:_____
Mother's/Legal Guardian's Name_____HomePhone:_____
Physician's Name _____Phone: _____
Name and age of siblings _____

IF YOU ANSWER YES TO ANY QUESTION, PLEASE EXPLAIN IN FULL ON BACK OF FORM

1. Has your child ever had any operations or serious illnesses? If yes, please explain. ☐ Yes ☐ No
2. Has your child had any serious accidents? If yes, please explain. ☐ Yes ☐ No
3. Does your child wear eyeglasses, contacts, braces, hearing aids, or any other corrective device? ☐ Yes ☐ No
4. Has your child had the following (Give month, year and/or age if known):

Chicken Pox _____	☐ Yes	☐ No	Heart condition _____	☐ Yes	☐ No
Pneumonia _____	☐ Yes	☐ No	Diabetes _____	☐ Yes	☐ No
Nosebleeds _____	☐ Yes	☐ No	Seizures _____	☐ Yes	☐ No
Frequent sore throats _____	☐ Yes	☐ No	High fevers _____	☐ Yes	☐ No
Ear Infections _____	☐ Yes	☐ No	Migraines _____	☐ Yes	☐ No
Eye condition _____	☐ Yes	☐ No	Other (please specify) _____		

5. Has your child had a neurological evaluation? If yes, when? _____ ☐ Yes ☐ No
6. Has your child had a psychological evaluation? If yes, when? _____ ☐ Yes ☐ No
7. Is your child restricted from physical activities? If yes, please explain. ☐ Yes ☐ No
8. Is your child allergic to: medicines/drugs? If yes, please specify. ☐ Yes ☐ No
   Is your child allergic to: plants/foods? If yes, please specify. ☐ Yes ☐ No
   Is your child allergic to: insect stings? If yes, please specify. ☐ Yes ☐ No
9. If you answered yes to question #8, does your child take medicine for this allergy? ☐ Yes ☐ No
   If yes, please specify. (i.e. Benadryl, Epi-Pen, etc.) _____
10. Does your child have asthma? If yes, date diagnosed: _____ ☐ Yes ☐ No
    If yes, what medication(s) does he/she take: _____
11. Does your child take any daily medications? If yes, please specify. _____ ☐ Yes ☐ No
12. Will medications be given at school? _____ ☐ Yes ☐ No
13. What medications are given frequently, but not daily? _____
14. Would you like a conference with the school nurse? ☐ Yes ☐ No

PROOF OF IMMUNIZATION MUST ACCOMPAY THIS FORM.

PARENT SIGNATURE: _____ **DATE**: _____