River Valley Local Schools

Health History

Student's Name: _____ Date of Birth: _____ Sex: Male Female

Mother's Name:		Phone #
Father's Name:		Phone #
Step-Mother's Name:		Phone #
Step-Father's Name:		Phone #
Siblings Name:	Age:	School:

Birth and Developmental History ☐ No unusual birth or developmental history

Did mother have any unusual physical or emotional illness during this pregnancy? Yes No

If yes, please explain:

Was infant born full term? Yes No, born at weeks Did infant spend any time in NICU? Yes No

Please explain issues or illnesses at birth:

Student Health Conditions ☐ **NO** medical concerns

My child receives regular medical/health care for the following conditions:

☐ Allergies	☐ Cystic Fibrosis	☐ Neuromuscular Disorder
☐ Asthma	☐ Diabetes	☐ Seizure Disorder
☐ ADD/ADHD	☐ Depression	☐ Sickle Cell Anemia
☐ Autism	☐ Ear problems/tubes	☐ Skin Conditions/Eczema
☐ Behavior Concerns	☐ Emotional concerns	☐ Speech Problems
☐ Birth/congenital malformations	☐ Headaches	☐ Traumatic Brain Injury
☐ Bone/muscle/joint problems	☐ Heart Problems	☐ Vision Problems (glasses/contacts)
☐ Blood disorders	☐ Hemophilia	☐ other: _____
☐ Bowel/bladder problems	☐ Juvenile Arthritis	☐ other: _____
☐ Cancer	☐ Lead Poisoning	☐ other: _____
☐ Constipation	☐ Migraines	☐ other: _____

Please explain any conditions, surgeries or hospitalizations:

_____

_____

_____

_____

Please complete information on the back of form

Allergies Please indicate any allergies your child may have.

		Circle one:
_____ Bee/Insect	Reaction: _____	Epi-pen YES or NO
_____ Medication	Reaction: _____	Epi-pen YES or NO
_____ Other allergies:	_____	Epi-pen YES or NO

Please list any food allergies:	Circle one:			Circle one:
Food: _____	Ingestion only	Contact only	BOTH ingestion + contact	Epi-pen YES or NO
_____	Ingestion only	Contact only	BOTH ingestion + contact	Epi-pen YES or NO
_____	Ingestion only	Contact only	BOTH ingestion + contact	Epi-pen YES or NO
_____	Ingestion only	Contact only	BOTH ingestion + contact	Epi-pen YES or NO
_____	Ingestion only	Contact only	BOTH ingestion + contact	Epi-pen YES or NO

Medications Please list any medications that your child takes on a daily basis, including vitamins or supplements.

_____

_____

_____

Will your child need to take medications at school? YES or NO (If yes, please request/submit medication administration form with medication.)

Please indicate any other information about your child's health and development that you think would be helpful for the school to know.

_____

_____

_____

_____

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Form completed by: _____

Relationship to the child: _____ Date: _____