LAMPETER-STRASBURG SCHOOL DISTRICT
1600 Book Road, P. O. Box 428
Lampeter, PA 17537

HEALTH HISTORY

Date: _______________ School Building: ___________________________________ Grade: ____________

Student's Name: ____ __________________
Last First Middle Date of Birth

Medications (Name and Dose): ____

____

Does your student have any of the following conditions? Allergy (Type): ____________________________

Asthma: _____________ Seizures: _____________ Diabetes: ____________ Headaches: ____________

Dental Problems (Explain): ____

Hearing Problems (Explain): ____

Eye Problems (Explain): ____

Wears Glasses: _________________ Wears Contacts: _________________

Hospitalizations/Operations (Reason/Date): ____

____

Has your student had any of the following illnesses?

________Anemia	________Skin Condition	________Mononucleosis
________Arthritis	________Sinus Problems	________Mumps
________Blood Pressure Issues	________Urinary Tract Infections	________Polio
________Cancer or Tumors	________Tuberculosis or Positive TB Test	________Pneumonia
________Constipation	________Chicken Pox (Date:___________)	________Rheumatic Fever
________Diarrhea	________Hepatitis (Type:______________)	________Scarlet Fever
________Eczema	________Measles	________Strep Throat
________Heart Disease	________Meningitis	________Whooping Cough
________Heart Murmur	________HIV/AIDS	

Describe:____

Other Illnesses (Specify): ____

Emotional/Behavioral History (Note Special Problems/Age of Occurrence):

Anger: ___________________________________ Depression: ___________________________________

Eating Disorder: ___________________________ Wetting/Soiling: ______________________________

Other: ____

Is your student restricted in physical activities (Explain)?____

____

Learning Disabilities (Explain): ____

Speech Difficulty (Explain): ____

Parent's/Guardian'sSignature: _______________________________________ **Date:** _____________

Parent's/Guardian's Print Name: ____