Student Name _____

Date Completed _____

Student's Health History Update

Grade 6 and 11

Health History

Please check if the student FREQUENTLY experiences any of the following: ☐ None known

- ☐ Nosebleeds
- ☐ Colds (6 or more in a year)
- ☐ Headaches
- ☐ Sore throat
- ☐ Throat infection (6 or more in a year)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomachaches
- ☐ Dental problems
- ☐ Menstrual Difficulties
- ☐ Chest pain
- ☐ Poor sleep patterns
- ☐ Persistent cough
- ☐ Earaches
- ☐ Poor eating patterns
- ☐ Difficulty breathing with physical activity
- ☐ Difficulty breathing through nose
- ☐ Snoring at night
- ☐ Pain in the arms or legs
- ☐ Swollen joints

Medical History – Please check all that apply. None known ☐

- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Birth Defect
- ☐ Blood Disorder (anemia, clotting disorder)
- ☐ Bloody Stools
- ☐ Cancer
- ☐ Dental Condition
- ☐ Diabetes
- ☐ Dietary Restrictions
- ☐ Chicken Pox
- ☐ Developmental Delay
- ☐ Eating nonfood items (paint/plaster)
- ☐ Emotional/Behavioral Condition
- ☐ Jaundice or Liver Problems
- ☐ Joint/Bone/Muscle Problem
- ☐ Immunosuppressive Disorder
- ☐ Stomach/Intestinal Disorder
- ☐ Fainting Spells
- ☐ Hearing Problems
- ☐ Heart Disorder
- ☐ Heart Murmur
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Migraine Headaches
- ☐ Measles
- ☐ Orthopedic Condition
- ☐ Neurological Disorder
- ☐ Pneumonia
- ☐ Psychiatric Condition
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Skin Disorder
- ☐ Speech Problems
- ☐ Tuberculosis
  - Has child ever had T.B. Skin Test? Results_____
- ☐ Vision Problems/Color Blindness
- ☐ Whopping Cough
- ☐ Other

Please explain condition(s) checked above or any other medical condition(s):

_____

_____

_____

Back →

Allergies ◯ Food ◯ Insect/Bee ◯ Medication ◯ Environmental/Seasonal ◯ Other ◯ None known

Specify Allergen: _____ Treatment: _____

Does your child take any daily medication? If so, please list the medication, dosage, and reason for taking.

_____

_____

Do you have any concerns regarding your child which you would like to discuss with the school nurse? If so, please explain briefly.

_____

_____

_____

Form Completed By _____ Date _____

Student Name ______________________________

Date Completed ____________________________