



Please complete the health history information below in order for us to begin compiling your student's health record at school.

Thank you,

District 28 Health Offices

Last			First			Middle			Birth Date Month/Day/ Year			Sex		School		Grade Level/ ID	
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER																	
ALLERGIES (Food, drug, insect, other)		Yes No		List:				MEDICATION (Prescribed or taken on a regular basis.)				Yes No		List:			
Diagnosis of asthma?				Yes		No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)				Yes		No			
Child wakes during night coughing?				Yes		No		Hospitalizations? When? What for?				Yes		No			
Birth defects?				Yes		No		Surgery? (List all.) When? What for?				Yes		No			
Developmental delay?				Yes		No		Serious injury or illness?				Yes		No			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.				Yes		No		TB skin test positive (past/present)?				Yes*		No		*If yes, refer to local health department.	
Diabetes?				Yes		No		TB disease (past or present)?				Yes*		No			
Head injury/Concussion/Passed out?				Yes		No		Tobacco use (type, frequency)?				Yes		No			
Seizures? What are they like?				Yes		No		Alcohol/Drug use?				Yes		No			
Heart problem/Shortness of breath?				Yes		No		Family history of sudden death before age 50? (Cause?)				Yes		No			
Heart murmur/High blood pressure?				Yes		No											
Dizziness or chest pain with exercise?				Yes		No											
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																	
Ear/Hearing problems?				Yes		No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____ Information may be shared with appropriate personnel for health and educational purposes.									
Bone/Joint problem/injury/scoliosis?				Yes		No		Parent/Guardian Signature _____ Date _____									