



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			Sex		School		Grade Level/ ID		
									Month/Day/ Year									
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																		
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes No	List:					<b>MEDICATION</b> (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				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other										
Dizziness or chest pain with exercise?			Yes	No				Information may be shared with appropriate personnel for health and educational purposes.										
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Yes	No				<b>Parent/Guardian</b>										
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Yes	No				<b>Signature</b>										
Ear/Hearing problems?			Yes	No				<b>Date</b>										
Bone/Joint problem/injury/scoliosis?			Yes	No														