STUDENT HEALTH HISTORY

Student Name:_____ Sex:_____ Age: _____

Date & Place of Birth:_____

Address:_____ Home Phone Number:_____

Guardian 1 Name: _____ Phone Number:_____

Guardian 2 Name: _____ Phone Number:_____

History:

Were there any issues during pregnancy, labor and/ or delivery for this child? ☐ Yes ☐ No

If “yes”, please describe:_____

Was baby born on time, early, late? _____ Birth Weight? _____

Is there a history of any hospitalizations, significant injuries or surgery? ☐ Yes ☐ No

If “yes”, please describe:_____

Has your child ever had a seizure? ☐ Yes ☐ No

Did your child ever have a head injury? ☐ Yes ☐ No

List any significant medical concerns in family:

☐ Mother _____ ☐ Father _____

☐ Siblings _____ ☐ Grandparents _____

☐ Other _____

Current Health:

Does this child have an ongoing health concern? (asthma, diabetes, etc.) ☐ Yes ☐ No

If “yes”, please describe:_____

Are there any current medical concerns/injuries? ☐ Yes ☐ No

☐ Head _____ ☐ Eyes _____ ☐ Nose _____

☐ Ears _____ ☐ Throat _____ ☐ Neck _____

☐ Chest _____ ☐ Respiratory _____

☐ Cardiovascular _____ ☐ Gastrointestinal_____

☐ Genitourinary _____ ☐ Neurological _____

☐ Musculoskeletal (include any past fractures, etc.) _____

Do you have any reason for believing your child has a vision or hearing problem? ☐ Yes ☐ No

If “yes”, please describe:_____

Does your child wear glasses? ☐ Yes ☐ No

If “yes”, Glasses help with near ☐, distant ☐, other ☐ vision?

Does this child have any allergies? ☐ Yes ☐ No

If “yes”, please list: _____

_____

Has the allergy required emergency treatment? ☐ Yes ☐ No

Does your child have an Epi-pen? ☐ Yes ☐ No

If “yes”, please explain: _____

Are the child’s immunizations up to date? ☐ Yes ☐ No

Additional immunizations required: _____ Do you have an appointment date? _____

Does this child take any medication regularly at home? ☐ Yes ☐ No

Require medication at school? ☐ Yes ☐ No

If “yes”, please describe:_____

Describe child’s nutritional pattern and dietary intake:_____

Is your child on a special diet? ☐ Yes ☐ No

If “yes”, please describe:_____

Who lives with the child in their primary household? _____

Does the child spend a significant amount of time in another household? ☐ Yes ☐ No

If “yes”, please describe:_____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

Do you have any additional concerns or pertinent information?

_____

_____

_____

_____

Two local neighbors or relatives (within 15 to 20 minutes) who would be able to pick up and take care of child in the event of illness or injury when the parent is not at home or cannot be located:

Name: _____

Address: _____ Phone Number: _____

Name: _____

Address: _____ Phone Number: _____

Doctor to be called in an emergency: _____ Phone Number: _____

Preferred Hospital? _____

Date: _____ Signed: _____ Print: _____