STUDENT HEALTH HISTORY

To be completed each school year by parent or guardian.

Student's Name_____ School Year_____

Grade_____ Birthdate_____ Male / Female

Doctor_____ Doctor's Phone_____

HEALTH CONCERN			**EXPLAIN / DESCRIBE**
Allergies	No	Yes	_____
*Life Threatening	No	Yes	_____
Asthma	No	Yes	_____
*Inhaler	No	Yes	_____
Blood Disorder	No	Yes	_____
Bladder or Bowel Problems	No	Yes	_____
Bone/Joint/Musculoskeletal Problems	No	Yes	_____
Daily Medications	No	Yes	_____

*Names of Medications (include those taken at home) _____

"At-school" medications require new Unit 5 Medication Administration Form each year.

Diabetes	No	Yes	_____
Ear/Hearing Problems	No	Yes	_____
Eye/Vision Problems	No	Yes	_____
Glasses/Contacts	No	Yes	_____
Headaches	No	Yes	_____
Heart Problems	No	Yes	_____
Hospitalizations	No	Yes	_____
Mental Health Concerns	No	Yes	_____
Neurological Problems	No	Yes	_____
Physical Restrictions	No	Yes	_____
Seizures	No	Yes	_____
Serious Injuries	No	Yes	_____
Surgeries	No	Yes	_____

Other Health Concerns:_____

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- **It is the parent's responsibility to contact the School Nurse with any health changes during the school year.**
- **Relevant health information will be shared with school personnel involved in the welfare and safety of your child during the school day.**

_____ _____

Parent/Guardian Signature Date