HAMILTON TOWNSHIP BOARD OF EDUCATION
DEPARTMENT OF STUDENT SERVICES AND PROGRAMS
OFFICE OF SCHOOL HEALTH SERVICES
STUDENT HEALTH HISTORY - SECONDARY

It is necessary for school health personnel to have complete health information on each student in order to better understand individual needs, and to develop a permanent health record.

Please read the following and complete all information requested:

School student attended last: _____

Address of School: _____

Phone Number: _____

HEALTH HISTORY AND ASSESSMENT

Name: _____ **School:** _____

DOB: _____ **Male:** _____ **Female:** _____

Name of student's physician: _____ Phone Number: _____

If you answer **YES** to any of the following questions, please describe in the space provided:

Were there any significant injuries/illnesses during pregnancy?	Yes	No
Were there any complications during delivery?	Yes	No
Did student have any developmental delays?	Yes	No
Has student ever been hospitalized? If YES, give dates: _____	Yes	No
Has student had any significant injuries or illnesses?	Yes	No
Is there a history of surgery?	Yes	No
Is there a history of hearing problems?	Yes	No
Is there a history of vision problems?	Yes	No
Is there a history of orthopedic problems?	Yes	No
Is there a history of seizures?	Yes	No
Is there a history of asthma/allergies?	Yes	No
Does student have any food allergies?	Yes	No
Does the student have any medical restrictions preventing participation in PE?	Yes	No
Does the student have any physician documented history of concussions?	Yes	No
Does the student take any medications?	Yes	No

If you answered YES to any of the questions above, please explain: (attach additional page if needed)

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Thank you for sharing this information with us. Please be assured that any information of a confidential nature will be treated with respect.

_____ _____ _____

Parent/Guardian Signature Student Signature Date

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