

STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Age:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Grade:	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐ food ☐ environmental ☐ insect ☐ medication ☐ other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|---|---|---|
| ☐ ADHD | ☐ GI Conditions (ulcer, reflux, IBS) | ☐ anxiety, OCD, ODD, etc.) |
| ☐ Asthma/trouble breathing | ☐ Headaches/migraines | ☐ Scoliosis |
| ☐ Autism/Asperger | ☐ Heart Conditions | ☐ Single Organ (☐ kidney, ☐ testicle) |
| ☐ Dental Injuries | ☐ High Blood Pressure | ☐ Skin Condition |
| ☐ Diabetes | ☐ Mental Health Condition | ☐ Speech Condition |
| ☐ Ear Infections | (depression, eating disorder, | ☐ Urinary Condition |

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ wheelchair ☐ other:
TREATMENTS	YES	NO	
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ inhaler/nebulizer/peak flow monitoring ☐ special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____