Mt. Lebanon School District

HEALTH HISTORY (parent completes)

Student's Name_____Grade/HR_____ Date of Birth_____

Street Address_____

City_____Zip _____ Cell/Home Phone_____

Siblings name	Birth Date	School	Grade

Name and address of school last attended:

Name of school:

Address of school:

Physician:_____ Phone Number:_____

Dentist:_____ Phone Number: _____

Medication: (please list all medications taken):

At Home: _____

At School:_____

(If required at school, complete form ***- Authorization for Medication****)*

OVER

STUDENT NAME:_____ **GRADE/HR:**_____

TO BE COMPLETED BY PARENT

Please check ✔ ALL that applies to your child

Anxiety		*Developmental Delay*		*Nosebleeds*	
Arthritis		*Diabetes Type 1*		*Orthopedic Condition*	
Asthma		*Diabetes Type 2*		*Rheumatic Disease*	
Attention Deficit Disorder		*Dietary Restrictions*		*Sickle Cell*	
Autoimmune Disorder		*Epilepsy/Seizure Disorder*		*Speech Difficulty*	
Bladder/Bowel Control		*Gastrointestinal Condition*		*Spina Bifida*	
Bleeding Disorder		*Hearing Deficit (right/left)*		*TB Exposure*	
Blood Pressure Issues - (high or low)		*Immunocompromised*		*Thyroid Condition - specify*	
Cancer		*Inflammatory Bowel Disease*		*Tourette's Syndrome*	
Cardiovascular Condition - specify		*Kidney Condition*		*Vision:* *Eye Surgery - specify*	
Cerebral Palsy		*Mental Health Diagnosis*		*Severe Vision Loss - right/left*	
Chicken Pox(date)		*Migraines*			
Color Vision Deficiency		*Neurological Disorder*			
Dental Condition					

*Explain Above Check Marks:*_____

*Allergies/Reaction:*_____

*Previous Surgeries/Dates:*_____

Other: _____

I understand and agree that any and all of this information may be shared with appropriate school personnel.

_____ _____

Parent/Guardian Signature Date

_____ _____

Signature of Certified School Nurse Date