



Ipswich Public Schools

Student Health History

Student Name: _____ DOB: _____ Grade: _____

Allergies: If your child requires emergency medication for anaphylaxis, please contact school nurse.

Allergy	Reaction	Treatment

Health Conditions: Check all that apply and describe

☐	ADD/ADHD	☐	Heart Condition
☐	Asthma or Respiratory Condition	☐	Mental Health Condition
☐	Autism	☐	Neurologic Condition
☐	Blood Disorder	☐	Surgical History
☐	Bowel/Bladder Condition	☐	Scoliosis
☐	Diabetes	☐	Seizure Disorder
☐	Hearing or Vision Impairment	☐	Skin Condition
☐	Other:		

Additional comments:

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

If yes, please describe and provide medical documentation: _____

(Signature of Parent/Guardian)

(Date)

Printed Name