Roseland School District

Student Health History

Date: ______/_______/_______ School: ________________________

Student's Name: ____

☐ Male ☐ Female ☐ Nonbinary Birthdate: ________/________/________

Parent/ Guardian: ____

Telephone: Home (______) ____________________ Cell (______) ____________________

Address: ____
Street Apt. City Zip

Has your child had any of the following?

☐ Chicken Pox ☐ Tuberculosis ☐ Diabetes
☐ Asthma ☐ Allergies ☐ Stinging Insect Allergy
☐ Heart Problems ☐ Behavior Problems ☐ Convulsion, Seizures
☐ Frequent Colds ☐ Recurring Ear Infections ☐ Eye Problems
☐ Movement Limitation
☐ Recent illness, hospitalization, surgery or other physical conditions which limits your child's physical activity at school.

Please provide additional information for any of the above conditions checked:

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All medication sent to school must be in the prescription container with the current date.
Does your child require medication while at school? ☐ Yes ☐ No
If Yes, please complete an *"Authorization for Administration of Medication"* (obtain form from the school office)
Please indicate:
Medication: ______________________ Dosage: ______________ Hour(s) given: ____________________
Medication: ______________________ Dosage: ______________ Hour(s) given: ____________________

Date of last physical exam: _______/______/________ Doctor: ______________________________

Date of last dental exam: ________/_______/_______ Dentist: ____________________________

Does your child wear glasses: ☐ Yes ☐ No
Does your child have any medical conditions which might require care while at school or which restrict his/her physical activity, such as in contact sports? *(Please Describe)*

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Information obtained from this health history may be included on a confidential health conditions list, if appropriate. For more information/concerns, please contact the school nurse.

____ ______________________________
Parent Signature Date