Student Health History 2020/2021

Student's Name: _____ Date of Birth_____

Gender (circle): M / F Grade: _____ New_____ or Returning student_____

Physician's Name: _____ Phone #: _____

Does the student have any of the following health conditions?

Health condition	Yes	No	**Comments:** Include all dates, symptoms, and treatments as they apply
Asthma*			
Seasonal allergy			
Food allergy *			
Insect allergy*			
Medication allergy			
Diabetes*			
Heart problems			
Kidney problems			
Eye/ vision issues			
Wears glasses			Last eye exam date:
Frequent ear infections			
Ear tubes			
Hearing problems			
Wears hearing aids			
Cochlear implant			
Eczema/ skin rash			
Seizures*/ fainting			
Bleeding tendencies			I.e, frequent nose bleeds
Physical handicap			
Speech/ language difficulties			Speech therapy facility:
Special dietary needs**			

***Additional form required **Physician's order required**

Has the student ever had the following:

Condition	Yes	No	Details
Head injury			
Broken bones			
Surgeries			

Does the student take any medications on a regular basis? Yes ____ (list below) No_____

Medication	Dose	Time	Reason for giving	Taken at school

The school nurse has permission to share information with school staff as she determines appropriate for my child's health and safety. Yes_____ No_____

I authorize the school nurse to contact my child's physician regarding any listed medical condition, immunizations, or medication regimen for further information or to develop an individual health plan. Yes_____ No_____

_____ _____ _____

Parent/Guardian Signature *Printed Name* *Date*