SCHOOL HEALTH SERVICES
STUDENT HEALTH HISTORY

Student_____ Date of Birth_____ Sex_____ Grade_____
Address_____ Phone(___)_____
Mother_____ Father _____Guardian_____
Has child had chicken pox disease? No___ Yes___, date of disease_____
Check items that student has had or currently has:
Allergies:
□ Food □ Medication □ Bee Sting □ Insect Bite □ Other
Comments_____
Respiratory:
□ Asthma □ Bronchitis □ Chronic Cough
□ Frequent Colds □ Pneumonia □ Tuberculosis □ Other
Comments_____
Cardiac:
□ Heart Murmur □ Congenital Defect □ Arrythmias □ Other
Comments_____
Eyes, Ears, Nose, Throat:
□ Ear Aches □ Hearing Loss □ Sore Throat
□ Speech Difficulties □ Visual Impairment □ Other
Comments_____
Gastrointestinal:
□ Gastric Reflux □ Stomach Aches □ Toileting Problems □ Other
Comments_____
Genitourinary:
□ Urinary Accidents □ Urinary Tract Infections □ Other
Comments_____
Neurological:
□ A.D.D./A.D.H.D. □ Congenital Condition □ Convulsions
□ Developmental Delays □Headaches/Migraines □ Tourette's Syndrome □ Other
Comments_____
Skeletal:
□ Fractures □ Orthopedic Condition □ Scoliosis □ Other
Comments_____
Emotional:
□ Depression □ Suicide □ Family Stressors □ Other
Comments_____
Chronic Conditions:
□ HIV/AIDS □ Cancer □ Diabetes □ Epilepsy □ Blood Disorders
□ Genetic Conditions □ Arthritis □ Other
Comments_____
Describe any serious illnesses, accidents or operations your child has had:_____
_____
Family History – has any family member had:
□ Cancer □ Disease □ Diabetes □ HIV/AIDS □ Heart Disease
Comments_____
□ Child currently under medical treatment – explain _____
□ Child currently taking daily medication – explain _____
Areas of concern or information that would be helpful to school staff: _____
_____
Parent Signature _____ Date _____