SCHOOL HEALTH SERVICES & STUDENT HEALTH HISTORY

Student's Full Name: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____ ***(mm/dd/yyyy)*** Sex _____ Grade _____

Mother _____ Father _____ Guardian _____

Has child had chickenpox disease? YES _____ NO _____, if yes date of disease _____ ***(mm/yyyy)***

Describe any serious illnesses, accidents or operations your child has had: _____

Check items that student has had or currently has:

Allergies: □ Food □ Medication □ Bee Sting □ Insect Bite □ Other
Comments _____

Respiratory: □ Asthma □ Bronchitis □ Chronic Cough
□ Frequent Coughs □ Pneumonia □ Tuberculosis □ Other
Comments _____

Cardiac: □ Heart Murmur □ Congenital Defect □ Arrhythmias □ 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
□ Other
□ Developmental Delays □ Headaches/Migraines □ Tourette's syndrome
Comments _____

Skeletal: □ Fractures □ Orthopedic Condition □ Scoliosis □ Other
Comments _____

Emotional: □ Depression □ Suicide □ Family Stressors □ Other
Comments _____

Chronic Conditions: □ HIV/AIDS □ Cancer □ Diabetes □ Epilepsy
□ Genetic Conditions □ Arthritis □ Blood Disorders □ Other
Comments _____

Family History: ***(has any family member had):***
□ Cancer □ 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 _____

_____

Parent/Guardian Signature: _____ Date: _____