STUDENT HEALTH HISTORY (TO BE COMPLETED BY PARENT)

STUDENT _____ **GRADE** _____ **HOMEROOM** _____

Sex: ____ Male ____Female **Date of birth** _____/_____/_____

Please complete this form and return it to school as soon as possible. If there are any future changes in your child's health status, please call Peggy Brockmeier, RN or send a note to school. **Check all health conditions your child may have.**

- ▫ **ADD / ADHD**
- ▫ **ALLERGIES** or reactions to: (Please explain)

Food(s) _____

Medication(s) _____

Plant / Animal / Environmental _____

_____

- ▫ **ASTHMA** (Identify triggers)

_____

Has your child ever needed emergency treatment for asthma?

___ YES ___ NO

- ▫ **BLADDER PROBLEMS** (Please explain)

_____

- ▫ **BOWEL PROBLEMS** (Please explain)

_____

- ▫ **DEVELOPMENTAL DELAY** (Please explain)

_____

- ▫ **DIABETES** Age of diagnosis _____
- ▫ **EAR INFECTIONS** (frequently after age of 3)

Approximate date or age of last infection _____

Currently under the care of ENT? ___ YES __ NO

Currently has PE tubes? ___ YES ___ NO

_____ Wears hearing aid in right/left ear (circle)

_____ Has hearing loss in right/left ear (circle)

- ▫ **EATING DISORDER**
- ▫ **EMOTIONAL/ BEHAVIORAL CONCERNS**
- ▫ **EYE PROBLEMS** (Please explain)

_____

Wears glasses/contacts? ___ YES ___ NO

___ wears all the time or ___ for reading ___ for distance

- ▫ **HEADACHES** (frequent)

Migraines? ___ YES ___NO

- ▫ **HEART CONDITION** (Please explain)

_____

- ▫ **KIDNEY DISEASE** (Please explain)

_____

- ▫ **PHYSICAL DISABILITY** (Please explain)

_____

_____

- ▫ **RECENT HOSPITALIZATION/SURGERY**

SIGNIFICANT INJURY (Please explain)

_____

- ▫ **SEIZURES / EPILEPSY**

Date of last episode _____

- ▫ **SPINAL CURVATURE (**scoliosis, etc.)
- ▫ **TICS / NERVOUS TWITCHES**

Has your child traveled outside the United States in the past year? _____ No _____ Yes _____ (Where?)

My child takes the following daily medication(s) _____

My child takes the following medication(s) occasionally _____

Please identify any other health information not listed above that you believe school personnel need to be aware of:_____

_____

List any health conditions that require school restrictions, modifications, and/or interventions: _____

_____

This information may be shared with school personnel if it is pertinent to health and safety, educational progress and/or behavioral management plan.

Parent/Guardian Signature_____ **Date** _____