STUDENT HEALTH HISTORY

Students Name_____ Date _____

THIS INFORMATION WILL BECOME PART OF YOUR STUDENTS EDUCATIONAL RECORD AND MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL FOR EDUCATIONAL OR SAFETY PURPOSES.

PREGNANCY: Were there any problems during pregnancy, birth, or shortly thereafter? Yes ☐ No ☐
If yes, please explain _____

MILESTONES: At what age did your child begin to: crawl _____ walk _____ talk _____

PLEASE CHECK ANY HEALTH CONCERNS THAT APPLY:

☐ ALLERGIES
- ☐ Bee/Insect Sting _____ Describe Reaction _____
- ☐ Medication _____ Describe Reaction _____
- ☐ Food _____ Describe Reaction _____
- ☐ Environmental _____ Describe Reaction _____

☐ ASTHMA What starts an attack? ☐ Exercise ☐ Colds ☐ Allergies _____
☐ Smoke ☐ Other _____
List asthma medications _____

☐ ATTENTION DEFICIT DISORDER (ADD/ADHD) Treatment _____

☐ EMOTIONAL/BEHAVIORAL CONCERNS
Diagnosis _____ Treatment _____

☐ DIABETES ☐ Insulin Dependent ☐ Non- Insulin Dependent
☐ EATING/DIGESTIVE PROBLEMS
☐ KIDNEY/BLADDER PROBLEMS
☐ HEART PROBLEMS
☐ MUSCLE/JOINT/BONE PROBLEMS

☐ VISION ☐ CONTACTS ☐ GLASSES ☐ VISION LOSS ☐ COLOR BLIND ☐ OTHER _____
Date of last exam _____
☐ HEARING ☐ Hearing Loss Describe _____
☐ Frequent Ear Infections ☐ Tubes in Ears which ear? _____ age? _____
☐ Speech Therapy ☐ Hearing Aids

HEADACHES/MIGRAINES Frequency _____ Treatment _____
HEAD INJURY Date _____ Severity _____
SEIZURES Type _____ Frequency _____ Medication _____
PAST MAJOR ILLNESS/SURGERIES _____
MEDICATIONS ☐ Taken at home _____ ☐ Taken at school _____
OTHER MEDICAL CONDITIONS OR LIMITING PHYSICAL DISORDERS _____