**Health History (To be kept in health room)** Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_

Did your child weigh less than 5.5 lbs. at birth? \_\_\_\_\_ Y \_\_\_\_\_ N

Does your child have an Individual education Plan (IEP)? \_\_\_\_Yes \_\_\_\_ No

Please check if your child has or has ever had any of the following:

\_\_\_\_\_\_ Allergies \_\_\_\_\_\_ Asthma \_\_\_\_\_\_ Blood Anomalies (Ex., Anemia, Sickle Cell, Hemophilia) \_\_\_\_\_\_ Diabetes \_\_\_\_\_\_ Emotional Disorder \_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_High Blood Pressure

\_\_\_\_\_ Hyperactivity/ Attention Deficit Disorder \_\_\_\_\_\_Kidney Problems\_\_\_\_\_\_ Orthopedic Problems

\_\_\_\_\_\_Seizures Frequency of Seizures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Pneumonia \_\_\_\_\_\_ Speech Problems \_\_\_\_\_\_ Skin Problems \_\_\_\_\_\_ Special Dietary Needs

\_\_\_\_\_\_ Other

Please describe any problems checked above. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 List any medications that your child will take at school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicines your child is taking at home (not previously listed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tubes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child wear a hearing aid or other device? \_\_\_\_\_\_\_\_\_\_\_\_ Which ear(s)? \_\_\_\_\_ R \_\_\_\_\_ L

Eye Problems: \_\_\_\_Y \_\_\_\_ N Does the child wear glasses or contact lenses? \_\_\_\_ Y \_\_\_\_ N

Please list any other special accommodation(s) that may be required to meet your child’s needs most effectively while he or she is at school.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Primary Health Source**

My child receives regular medical care from:

\_\_\_\_\_\_ Emergency Room \_\_\_\_\_\_ Free Health Clinic

\_\_\_\_\_\_ Family Doctor Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Name for EMS Transport \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that information relating to my child’s allergies will be posted in the classroom, health room and cafeteria for easy access for school personnel. This form will be placed with the child’s confidential records.
* I understand that routine health screenings (vision, hearing, and dental) will be conducted by the school.
* I understand that staff members will administer basic first aid and contact EMS for more advanced care if deemed necessary.

Parent’s/Guardian’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_