STUDENT
NAME:_____DOB:_____
Health History
(Please check appropriate column, note year, and explain where applicable.

Allergy Types	**Reaction**	**Implications for school**
Bee		
Drugs		
Food		
Latex		
Pollen		
Skin		
Other (i.e. seasonal)		

Other Conditions	**No**	**Yes**	**Year(s)**	**Explain**
Asthma/Reactive Airway				
Bed wetting				
Blood Disorder				
Cancer				
Concussion/Head Trauma				
Diabetes				
Digestive(constipation /Feeding Disorder				
Disease i.e. chickenpox				
Dietary Restrictions				
Emotional Problems				
Genito/urinary Problems				
Hearing Difficulty				
Heart Disease (defects)				
Hospitalizations				
Infections				
Kidney Disease				
Neuro-muscular disorders/prosthesis				
Organs missing or impaired function of paired organs; i.e. kidneys, testes, eyes				
Seizure Disorder				
Skin Disorder				
Speech Impairment				
Surgical Procedures				
Vision Problems(glasses)				
Other (list and explain) Serious illnesses, accident, genetic disorders)				

A. Is the student receiving medication? Yes___ No___
If yes, complete the following:

Medication(s)	Dose	Times	Reason	Date prescribed	Prescribing Physician

B. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention? Yes___ No___
If yes, explain_____

_____

_____

C. Does the student require any special procedures and/or treatments?
Yes___ No___
If yes, explain_____

_____

D. Is the student currently under treatment for any health conditions?
Yes___ No___
If yes, complete the following:

Condition	Physician	Treatment

Parent Signature_____

Date_____