STUDENT HEALTH HISTORY
2020/2021

STUDENT'S NAME_____BIRTHDATE_____

HOMEROOM TEACHER_____GRADE_____DATE_____

HOME PHONE NUMBER_____MOTHER'S WORK NUMBER_____FATHER'S WORK NUMBER_____

In case of an emergency, contact (please list someone other than parent)

1._____Phone:_____

2._____Phone:_____

Has your child had the following: (give dates if known)

Heart Disease □ Yes □ No Date:_____

Kidney Disease □ Yes □ No Date:_____

Rheumatic Fever □ Yes □ No Date:_____

Convulsions □ Yes □ No Date:_____

Diabetes □ Yes □ No Date:_____

Asthma □ Yes □ No Date:_____

Pneumonia □ Yes □ No Date:_____

Tuberculosis □ Yes □ No Date:_____

Chicken Pox □ Yes □ No Date:_____

Mumps □ Yes □ No Date:_____

Measles, Red □ Yes □ No Date:_____

Major Illnesses □ Yes □ No Date:_____
Specify:_____

Significant Injuries □ Yes □ No Date:_____
Specify:_____

Glasses □ Yes □ No Date:_____

Hearing Aids □ Yes □ No Date:_____

Other:_____

MY CHILD IS ON THE FOLLOWING DAILY MEDICATION(S):_____

My child is allergic to the following:

Penicillin □ Yes □ No Comments:_____

Aspirin □ Yes □ No Comments:_____

Tylenol □ Yes □ No Comments:_____

Foods □ Yes □ No Comments:_____

Other □ Yes □ No Comments:_____

PHYSICIAN INFORMATION:

Is your child under a doctor's care? □ Yes □ No Physician's Name_____

Dentist/Orthodontist_____ Hospital Preference_____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

THIS CERTIFIES THAT PERMISSION IS GIVEN FOR SCHOOL AUTHORITIES TO SEEK EMERGENCY MEDICAL TREATMENT FOR THE ABOVE NAMED STUDENT IN THE EVEN A PARENT OR EMERGENCY FRIEND CANNOT BE CONTACTED IMMEDIATELY.

Signature of Parent or Guardian_____Date_____

This form is to be completed by a parent/guardian. This information will enable the school nurse to establish/maintain a comprehensive health history and health appraisal record system. Please have your child return this form to his/her homeroom teacher for referral to the school nurse.