

STUDENT HEALTH HISTORY

2021/2022

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: _____ Chicken Pox Yes No Date: _____

Kidney Disease Yes No Date: _____ Mumps Yes No Date: _____

Rheumatic Fever Yes No Date: _____ Measles, Red Yes No Date: _____

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

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

Asthma Yes No Date: _____ Glasses Yes No Date: _____

Pneumonia Yes No Date: _____ Hearing Aids Yes No Date: _____

Tuberculosis 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.