STUDENT HEALTH HISTORY
2017/2018

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.