HEALTH HISTORY

This form is to be completed by the parent/guardian and submitted to the school. All information is considered confidential.

STUDENT NAME: _____ **DATE OF BIRTH:** _____

DATE: _____ **GRADE:** _____ **GENDER:** ____ **PHONE:** _____

Has your child had any of the following? Please indicate Yes/No and dates.

	Yes	No	Date	Nature of Concern/Comments
Stinging insect allergy				
Allergies - Food/Med/Other				
Asthma				
Convulsions, Seizures				
Heart disease				
Diabetes				
Glasses				
Hearing Aid				
Ear trouble				
Tonsils removed/T & A				
Frequent colds				
Other diseases (list at right)				
Serious accidents/illnesses				
Behavior/Emotional Difficulties				
Physical Limitations				
Speech Concerns				
Operations (list at right)				
Present Medications (list at right)				

If your child will need a medication dose at school, please complete the Authorization to Administer Medication at School Form and return to the school office. No medication, either prescription or over-the-counter, will be administered without a form completed by a health care provider *and* parent.

Name of Doctor _____ Date Last Seen _____

Name of Dentist _____ Date Last Seen _____

Name of Specialist/Other Doctor _____ Date Last Seen _____

Parent/Guardian Signature _____

QUESTIONS? Contact District Nurse Laurel Yrun, R.N. at nurse@kentfieldschools.org