# HEALTH HISTORY

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

**DATE:_____ GRADE:____ SEX:____ PHONE:_____**

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

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

| | Yes | No | Date | Nature of Concern |
|---|---|---|---|---|
| Ear trouble | | | | |
| Tonsils removed T & A | | | | |
| Frequent colds | | | | |
| Stinging insect allergy | | | | |
| Asthma | | | | |
| Convulsions, Seizures | | | | |
| Heart disease | | | | |
| Diabetes | | | | |
| Serious accidents/Illnesses | | | | |
| Behavior/Emotional Difficulties | | | | |
| Physical Limitations | | | | |
| Speech Concerns | | | | |

| | Yes | No | Date |
|---|---|---|---|
| Tuberculosis | | | |
| T.B. in family of contact | | | |
| Other Diseases | | | |
| | | | |
| | | | |
| | | | |
| Operations | | | |
| | | | |
| Present Medications | | | |

If child will need medication dose at school, please contact school for Medication at School Form. No medication, either prescription or over-the –counter will be administered without form completed by a health care provider *and* parent.

Name of Doctor _____ Date Last Seen_____

Name of Doctor _____ Date Last Seen_____

Name of Eye Doctor _____ Date Last Seen_____ Glasses?_____

Name of Ear Doctor _____ Date Last Seen_____ Hearing Aid?_____

Parent/Guardian Signature:_____