FOR PARENT TO COMPLETE
Health History

Student's Name_____ **Birthdate**_____

Dear Parent/Guardian:

In order to provide better health services to your child, we ask that you complete the following health history. Please give dates if possible.

Date of last physical examination: _____ Physician's Name: _____

Date of last dental examination: _____ Dentist's Name: _____

Does your child have any of the following?
If you answer yes to any of them, please explain at the bottom.

_____ Asthma	_____ Diabetes	_____ Convulsions/seizures
_____ Bone/joint disease or injury	_____ Headaches	_____ Heart problems/murmurs
_____ Ear infections	_____ Kidney problems	_____ Communicable diseases
_____ Allergies (food, medications, seasonal, environmental)		_____ Sinus/Respiratory problems

Explain:_____
_____

_____

Past injuries/accidents
(Explain)_____

_____

Past hospitalizations/operations
(Explain)_____

_____

Does your child have problems with vision, hearing or speech? _____

Does your child have any dietary modifications or limitations? _____

Student's Name_____ **Birthdate**_____

Does your child take any prescription and/or over the counter medicine? _____

Name of medication: _____

Reason for medication: _____

Dosage and times given: _____

Name of medication: _____

Reason for medication: _____

Dosage and times given: _____

Name of medication: _____

Reason for medication: _____

Dosage and times given: _____

(Note: <u>All medications</u> must be brought to the school nurse by a <u>parent</u> or <u>guardian</u>. No medication can be administered at the school without written orders from your M.D.)

Does your child have any physical limitations that may require program modification or restrictions?

_____

Please provide information on any other problems or comments you would like to bring to the attention of the school nurse or physician.

_____

_____

_____

Date_____

Parent Signature _____Print Name_____