

HEALTH HISTORY 2007-2008

This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health of the student. It is important that the questions be answered completely and accurately.

STUDENT NAME _____ GENDER _____ BIRTHDATE _____ GRADE _____

Parent/Guardian _____ Address _____ Zip code _____

Home phone _____ Mother's work phone _____ Dad's work phone _____

If a parent cannot be reached at any of the above phone numbers, whom should we contact in an emergency?

_____ Phone _____ Relationship to student? _____

Is student new to school district? NO YES If yes, list school district last attended? _____

Allergies

Allergy to medication	___ No	___ Yes	If yes, please list _____
Allergy to bee stings	___ No	___ Yes	If yes, please list type of reaction _____
Allergy to latex	___ No	___ Yes	_____
Allergy to any foods	___ No	___ Yes	List foods _____
Emergency Procedure Needed	_____		

Health Concerns

Please check any health concerns listed below that your student might have.

___ Vision	___ High Blood Pressure	___ Nosebleeds
___ Hearing	___ Headaches	___ Anemia
___ Speech	___ Seizure Activity	___ Surgery
___ Dental	___ Fainting Spells	___ Asthma
___ Heart	___ Urinary Problems	___ Allergies/Hay fever
___ Spine Problems	___ Diabetes	___ Eczema
___ Frequent Ear Infections	___ Degenerative Disease (Arthritis, MS, MD, etc.)	___ Attention Deficit Disorder
		___ Other _____

Does the above health concern require special attention at school? ___ No ___ Yes

Medication taken during the school year **at home**: _____

Reason for medication: _____

Medication taken during the school year **at school**: _____

Reason for medication: _____

Describe any ongoing physical or mental health concerns your child has:

Doctor Visits

Has the student seen a doctor during the last year for?

Physical Exam ___ No ___ Yes Date _____ Doctor _____

Dental Exam ___ No ___ Yes Date _____ Doctor _____

Vision Exam ___ No ___ Yes Date _____ Doctor _____

Insurance Information

Insurance/Medicaid _____ Member # _____ Group# _____

If your child does not have health insurance are you interested in receiving information about children's health insurance programs? ___ yes ___ no

I give my permission for confidential and discreet use of the above information to meet my child's health and educational needs at school.

Parent/Guardian Signature

Date

Original Copy of Health History should be filed in the above named student's folder in the health services office.