



STUDENT HEALTH HISTORY

(NOTE: One form *PER STUDENT* must be completed by parent or guardian.)

To: Parents or Guardians,

The State law requires that a school health record be kept for each pupil. Please complete and return this form to school as soon as possible. This information is necessary, as it provides the nurse with your child's specific health care needs during the school year.

_____	_____	_____
Student's Name/Grade/Teacher	Birth Date	Home Phone
_____	_____	_____
Parents' Names	Mom's Cell Phone	Dad's Cell Phone
	Mom's Work Phone	Dad's Work Phone
_____	_____	
Doctor's Name	Doctor's Phone	
_____	_____	
Dentist's Name	Dentist's Phone	

Please place a checkmark if your child has any of the following:

Allergies (Food, Nuts, Meds)	_____	Nosebleeds	_____
Asthma	_____	Pain in Joints	_____
Attention Deficit Disorder	_____	Physical Disability	_____
Autism Spectrum/Aspbergers	_____	Seizures	_____
Diabetes	_____	Sinus Infections	_____
Depression, Anxiety, OCD	_____	Speech Impairment	_____
Head Injury/Concussion	_____	Stomach Aches/Constipation	_____
Hearing Difficulty/Loss	_____	Vision Difficulty/Glasses	_____
Heart Disease	_____	Other Health Concerns	_____
Kidney Disease	_____		

**I give permission for this information to be shared with my child's teacher. _____ Yes
_____ No

Current Medication:(Include medication taken at home for ADHD, Anxiety, Depression)

For what condition? _____

Recent operations: _____

Parent/Guardian Signature: _____ Date: _____

