Student Health History

Please note: *This information is confidential. Information is only shared with staff in the interest of keeping students safe (such as where a stored medication is) or helping children learn (such as informing a teacher that a student wears glasses for reading). Please see the School Nurse if you have any concerns regarding your child's health or confidentiality.*

Student's Name_____ Student's Birthday___/___/__
Any known allergies?_____
Any history of allergic reactions?_____What happened?_____
Any seasonal allergies?____Is student on medication for allergies?____What type?_____
Any chronic respiratory condition, such as asthma?_____
If so, what are the triggers?_____
How is it controlled?_____
Should an inhaler/other med be kept at school?___**IF SO, PLEASE SEE THE NURSE.**
Any complications during pregnancy or birth?_____
Full term?_____Birth weight?_____

Any of the following?
Blood disorders_____
Muscular/Skeletal conditions_____
Heart conditions_____
History of seizures_____If so, what type_____
Stomach, bowel, urinary condition_____
Eyeglasses or other visual condition_____
Hearing or speech conditions_____
Skin condition or skin sensitivity_____
Enlarged tonsils or adenoids_____Surgery, past or planned?_____
How is the student's dental health?_____

History of:
Ear infections_____how many?____any ear surgery or intervention?_____
Strep throat or scarletina?_____
Chicken pox: Had disease_____Or had varicella vaccine?_____
Hyperactivity?_____Any medication?___Type_____Home or school?_____
Sleep habits_____
Eating habits_____
Any dietary restrictions?_____

Any other health concerns regarding your child? If so, please explain: _____
_____

Parent/Guardian signature_____Date___/___/____
Please print name_____