

# Student Health History

## 2009-2010

NAME \_\_\_\_\_ GRADE (2009-2010 School Year) \_\_\_\_\_

**1. MEDICAL HISTORY - Has your child ever had or now has:**

Yes	No	ADD/ADHD	Yes	No	Heart Condition
Yes	No	Asthma	Yes	No	Hepatitis
Yes	No	Anemia	Yes	No	Kidney/Urinary Problems
Yes	No	Arthritis	Yes	No	Orthopedic/ Bone Problems
Yes	No	Chickenpox	Yes	No	Pneumonia
Yes	No	Diabetes	Yes	No	Rheumatic Fever
Yes	No	Emotional Problems	Yes	No	Skin Conditions/Eczema
Yes	No	Epilepsy/Seizures	Yes	No	Tuberculosis
Yes	No	Fainting Spells	Yes	No	Valley Fever
Yes	No	Head Injury/Concussion			

Please use this space to explain items checked above: \_\_\_\_\_

\_\_\_\_\_

2. Does your child have allergies? YES \_\_\_ NO \_\_\_. If "Yes", to what (medication, pollens, insects, foods, etc.)?: \_\_\_\_\_

\_\_\_\_\_

3. Is your child under a doctor's treatment now? YES \_\_\_ NO \_\_\_

Reason: \_\_\_\_\_

4. Is your child taking any medication regularly? YES \_\_\_ NO \_\_\_

If "Yes", name of medication: \_\_\_\_\_

5. Does your child have any problems with: Speech - YES \_\_\_ NO \_\_\_; Vision - YES \_\_\_ NO \_\_\_; Hearing - YES \_\_\_ NO \_\_\_; Dental - YES \_\_\_ NO \_\_\_

If "Yes", explain: \_\_\_\_\_

\_\_\_\_\_

(over)

6. Has your child ever been hospitalized? YES \_\_\_ NO \_\_\_ Any operations? YES \_\_\_ NO \_\_\_

Any fractures, sprains? YES \_\_\_ NO \_\_\_ If "Yes", explain: \_\_\_\_\_

\_\_\_\_\_

7. Has your child ever had a very high fever? YES \_\_\_ NO \_\_\_ Seizures? YES \_\_\_ NO \_\_\_

If "Yes", explain: \_\_\_\_\_

\_\_\_\_\_

8. Does your child have:	Yes	No	Frequent colds	Yes	No	Toothaches
	Yes	No	Sore throats	Yes	No	Sinus trouble
	Yes	No	Nose bleeds	Yes	No	Frequent use of bathroom
	Yes	No	Earaches	Yes	No	Frequent constipation
	Yes	No	Headaches	Yes	No	Overactive bladder
	Yes	No	Stomachaches	Yes	No	Bedwetting

**ADDITIONAL COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**