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HEALTH HISTORY FORM FOR STUDENTS IN GRADES K-5

IN AN EFFORT TO PROVIDE YOUR CHILD WITH THE BEST HEALTH SERVICES, I REQUEST THAT YOU INDICATE IF YOUR CHILD HAS ANY OF THE FOLLOWING HEALTH PROBLEMS:

STUDENT NAME _____ Grade _____

ALLERGIES(If Yes, explain) _____

MEDICATION _____

ASTHMA _____ MEDICATION _____

BRONCHITIS _____

DIABETES _____

PHYSICAL DISABILITIES (PLEASE SPECIFY) _____

HEART PROBLEM _____ ANY LIMITATIONS? _____

IF YES, PLEASE SPECIFY _____

SKIN PROBLEMS _____

SEIZURE DISORDER _____ MEDICATION _____

FREQUENT NOSEBLEEDS _____ CAUSE IF KNOWN _____

FREQUENT USE OF BATHROOM _____ CAUSE IF KNOWN _____

FREQUENT HEADACHES _____ CAUSE IF KNOWN _____

VISUAL PROBLEMS _____

HEARING PROBLEMS _____

SPEECH IMPEDIMENTS _____

IF THERE ARE OTHER HEALTH PROBLEMS THAT WE SHOULD BE AWARE OF, PLEASE EXPLAIN ON THE BACK OF THIS FORM. PLEASE NOTIFY THE HEALTH OFFICE OF ANY SERIOUS INJURY OR OPERATION THAT MAY TRANSPIRE DURING THE SCHOOL YEAR. IF YOUR CHILD HAS BEEN PRESCRIBED ANY NEW MEDICATION PLEASE CONTACT THE SCHOOL NURSE IMMEDIATELY.

THANK YOU FOR YOUR COOPERATION
CAROL RICE, RN

PLEASE SIGN BELOW GIVING US PERMISSION TO SHARE MEDICAL INFORMATION AS NEEDED WITH APPROPRIATE STAFF MEMBERS.

PARENT'S SIGNATURE _____ DATE _____