HEALTH HISTORY

Child's Name: _____ Birthdate: _____ Telephone: _____

Parent's Name: _____ Address: _____

PLEASE CIRCLE YES IF CHILD EXHIBITS SYMPTOMS THAT COULD OCCUR AT SCHOOL

Nosebleeds	YES or NO	Fainting	YES or NO	Kidney Problems	YES or NO
Dizziness	YES or NO	Habitual cough	YES or NO	Headaches	YES or NO
Menstrual Pain	YES or NO	Mental Health	YES or NO	Respiratory	YES or NO
Tires easily	YES or NO				

Other (SPECIFY): _____ Other (SPECIFY): _____

PRESENT AND PAST HISTORY (Please list problems if necessary)

Allergies (Please list): _____ Ulcers: YES or NO

Allergies (Continued): _____

Asthma:	YES or NO	Diabetes:	YES or NO
Seizures:	YES or NO	Bee Sting Allergy:	YES or NO

Appendectomy: YES or No If yes, when? _____

Urination or elimination problems? YES or NO If yes, describe: _____

Orthopedic (Bones, Joints, Muscles, Feet): _____

Has your child had chickenpox? YES or NO If yes, when? _____

If no to having chicken pox, have vaccine? YES or NO If yes, when? _____

Contagious disease contracted? _____

Physical handicaps: _____

Pneumonia: YES or NO If yes, when? _____

Eye, ear, nose and throat conditions: _____

Tonsils and adenoids removed? YES or NO If yes, when? _____

Head injuries (concussions, etc.)? YES or NO If yes, when? _____

Heart conditions (murmurs, rheumatic fever, surgeries, other)? YES or NO

Does your child take medicine regularly? YES or No If yes, what? _____

Any activity restrictions for PE? YES or NO If yes, what? _____

*****A Physician's Note is required for any physical activity restrictions in PE*****

Please sign allowing this health information to be shared with appropriate personnel in the school to help work with your child to minimize unnecessary restriction, feeling of being treated differently, and possible absence from school. Please list any health information you would prefer not shared with staff members.

_____ _____

Parent/Guardian Signature Date