STUDENT HEALTH HISTORY

(to be filled out by parent)

Student Name_____Sex____ DOB_____Birthplace_____

Parent's Name(s)_____

Siblings (older)_____(younger) _____

Physician_____

Telephone_____

Dentist_____

Telephone _____

Orthodontist_____

Telephone_____

Does child speak English?_____ Language spoken at home _____

Significant prenatal, birth or early childhood developmental history _____

_____

Diseases or Conditions (past or present with dates)

Heart_____ Arthritis_____

Seizure Disorder_____ Asthma_____

Frequent ear infections_____ Frequent strep throats_____

Enuresis_____Pneumonia _____

Tuberculosis (or contact with known case)_____

Onset of menstruation_____Dysmennorhea _____

Chicken Pox_____Lyme Disease _____

Serious Illnesses_____Serious Injuries _____

Orthopedic conditions_____Limitations _____

Scoliosis_____

Operations_____

Hospitalizations (other than for surgery)_____

Allergies

Insect (specify) _____Type of reaction _____

Medication_____

Food Desensitization_____

Other

Speech difficulty_____Please describe_____

Eye condition_____Glasses_____Contact lenses_____

Hearing loss_____Treatment_____

On medication_____Reason_____

Please note any special health need such as behavior, growth nutrition, psychosocial, etc.

_____

Parent Signature_____ Date _____