Health History

ONLY COMPLETE AND RETURN THIS FORM IF YOU HAVE NOT DONE SO ELECTRONICALLY WHEN YOU REGISTERED YOUR CHILD OR IF YOUR CHILD HAS SPECIAL NEEDS OR MEDICAL PROBLEMS

Student Information

Name: ______________________________

Parent Contact Phone #: ______________________________

Mailing Address: ______________________________

Birth Date (M/D/Y): ____________ Sex: ☐M ☐F

Please check all that are applicable:

Session: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

Class(es): ______________________________

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In Case of an Emergency Please Notify:

Name: ______________________________

Address: ______________________________

Home Phone: ____________________ Work Phone: ____________________

Relationship ____________________

Medical Care Information

Has your child had or been treated for any of the following?

☐Epilepsy (Seizures) ☐High Blood Pressure ☐Diabetes ☐Heart Disease

☐Rheumatic Fever ☐Tuberculosis ☐Severe Allergies ☐Major Physical Disabilities

Is your child currently taking any drugs or medications ☐ Yes ☐ No

If "yes" please list ______________________________

Are there any medical problems, including allergies, that we should know about? (Inhalers, special medicine or bee sting kits, which must be carried by students at all times? ☐ Yes ☐ No

If "yes" please list ______________________________

Are there any special needs or conditions we should know about? ☐ Yes ☐ No

If "yes" please list ______________________________

Is your child allergic to Penicillin or any medications? ☐ Yes ☐ No

If "yes" please list ______________________________

Parent Signature: ______________________________ Date: ____________

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