



Student Health History Form

Student's name: _____ Preferred name: _____

Date of Birth: _____ Male: ☐ Female: ☐ Grade: _____ Teacher: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Please indicate any medications given at home, the dose, frequency and the reason for the medication.

HOME MEDICATION	DOSE	FREQUENCY	REASON GIVEN

ALLERGIES ☐ None Known ☐ Yes, specify details below

	NAME/TYPE	REACTION	TREATMENT
ANIMALS & INSECTS			
ENVIRONMENTAL			
FOODS			

HEALTH HISTORY – Please check if you child has ever had or currently has any of the following:

- | | | | |
|--|---|--|--|
| ☐ ADD/ADHD | ☐ Concussion | ☐ Migraines | ☐ Organ transplant |
| ☐ Arthritis | ☐ Dental disease | ☐ Hearing loss | ☐ Physical limitations |
| ☐ Asthma | ☐ Diabetes | ☐ Heart disease | ☐ Reproductive conditions |
| ☐ Autoimmune disease | ☐ Digestive disease | ☐ Hepatitis | ☐ Seizures |
| ☐ Birth defect | ☐ Eye conditions | ☐ Hospitalizations | ☐ Skin conditions |
| ☐ Blood disorder | ☐ Fractured/Broken Bones | ☐ Kidney or urinary disease | ☐ Surgery |
| ☐ Cancer (please specify) | ☐ Genetic disorder | ☐ Lung disease | ☐ Thyroid disease |
| ☐ Cognitive disorder | ☐ Glasses/Contact Lenses | ☐ Mental Health conditions | ☐ Other |

Please provide additional information (dates, ages, treatments, ongoing care, etc.):

By signing below, I understand this form must be updated prior to the beginning of each school year so that my child can remain in attendance.

Parent/guardian signature: _____ Date: _____