Health History

Student Name: _____ M / F Date of Birth: _____

Allergies	***Reaction***	***Recommended actions***
Bee Stings		
Food		
Medication		
Other		

Current Health conditions: <u>Mark all that apply</u>

Allergies	*Blood disorders*	*Headaches*	*Traumatic brain injury*
Asthma	*Cancer*	*Heart Problems*	*Vision problems*
ADD / ADHD / Behavior concerns	*Cystic Fibrosis*	*Migraines*	*Other:*
Autism	*Diabetes*	*Neuromuscular disorders*	
Bone / Muscle/ Joint/Spine problems	*Ear / hearing problems*	*Seizure disorders*	
Bowel / bladder problems	*Emotional concerns*	*Speech Problems*	

Please explain:

_____

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_____

_____

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Home medication and dose	***Time Given***	***Reason***

School medications And Dose ***Time Dose Due*** ***Reason***

List Surgeries or Past Medical Occurrences or Delays in Development:

_____
_____
_____
__

Additional information:

_____
_____
_____
__

Signature: _____ *Relation to student:* _____ *Grade:* _____

Printed Parent Name: _____ *Date Completed* _____