



Student Health Information Form

For Office Use Only:
SID:
School:

Student Name Date of Birth Grade

Physician's Name Phone#

Dentist's Name Phone#

PLEASE CHECK ALL THE FOLLOWING THAT THE STUDENT CURRENTLY HAS OR HAS HAD IN THE PAST:

- Allergies - List all Student has an Epi-Pen: Yes No
Food Reaction Recommended Treatment
Insect Stings Reaction Recommended Treatment
Plants/Animals Reaction Recommended Treatment
Medications Reaction Recommended Treatment
Asthma Student Uses an Inhaler at School: Yes No
Convulsions/ Seizures Frequency Medication
Diabetes Student uses Insulin: Yes No Student uses oral medication: Yes No
Attention Deficit Hyperactivity Disorder (ADHD/ADD) Medication:
Chicken Pox Disease Date
Ear Infections Frequency Age of last infection Tubes
Frequent Cold/ Sore Throat
Hearing Problems Describe Hearing Aid? Yes No
Heart Disease Describe
Kidney Disease Describe
Migraines Treatment
Rheumatic Fever Date
Sickle Cell Anemia
Skin Disorder Describe
Speech Problems Describe
Stomach / Intestinal Disorders Describe
Strep Infections Frequency Date of last infection
Tuberculosis
Vision Problems Describe Treatment
Other Physical Disabilities Describe

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Does your child take any medications daily? Specify Yes No
What medications are given frequently, but not daily?
Does your child have any emotional/behavioral health concerns? Yes No
Describe
Has your child ever had any operations or serious illnesses? Yes No
Explain
Has your child had any serious accidents? Yes No
Explain
Does your child wear eyeglasses, contacts, braces, or any other corrective devices? Yes No
Describe
Is your child able to participate fully in a physical education program? Yes No

Parent/Guardian Name (Please Print)

PARENT/GUARDIAN SIGNATURE DATE