HEALTH HISTORY

NAME____ BIRTHDATE____/____/_____GRADE_____
Last First Middle Mo / Day / Year

The following information may be helpful in assessing your child's heath/learning. If you do not wish to complete the entire form, you may wish to talk personally with our school office.

Has your child ever had any of the following? If "YES" please give age at the time.

			AGE				AGE
Yes	No	Allergies	____	Yes	No	Hepatitis	____
Yes	No	Asthma	____	Yes	No	High Blood Pressure	____
Yes	No	Anemia	____	Yes	No	Kidney Disease	____
Yes	No	Bronchitis	____	Yes	No	Mumps	____
Yes	No	Chicken Pox	____	Yes	No	Pneumonia	____
Yes	No	Convulsions	____	Yes	No	Osgood Schlatter's	____
Yes	No	Curvature of Spine	____	Yes	No	Red Measles	____
Yes	No	Cystic Fibrosis	____	Yes	No	Rheumatic Fever	____
Yes	No	Diabetes	____	Yes	No	Scarlet Fever	____
Yes	No	Frequent Ear Infections	____	Yes	No	Scoliosis	____
Yes	No	Eczema	____	Yes	No	Sinusitis	____
Yes	No	Epilepsy	____	Yes	No	Skin Rashes	____
Yes	No	Frequent Colds	____	Yes	No	Stomach Problems	____
Yes	No	Frequent Sore Throats	____	Yes	No	Strep Throat	____
Yes	No	German Measles	____	Yes	No	Tonsillitis	____
Yes	No	Heart Disease	____	Yes	No	Urinary Tract Infection	____

Yes No Is this child presently receiving treatment for any physical problem?
Yes No Taking medication?
Yes No Taking medication on a daily basis?
Yes No Restricted from physical activity?
Yes No Has this child ever had surgery?
Yes No Ever had a psychological examination?
Yes No Ever been placed in special classes? LD, Reading, Speech, Hearing Impaired, Visually Impaired, Emotionally Handicapped, Physically Handicapped, Other
Yes No Ever had a serious accident or injury?
Yes No Ever had an accident or injury requiring hospitalization?
Yes No Does your child wear glasses?
Yes No Have other vision difficulties?
Yes No Have any speech difficulties?
Yes No Have any hearing difficulties?
Yes No Have any hearing loss?
Yes No Wear a hearing aide (s)?
Yes No Has your child ever had tubes put in his/hers ears?
Yes No Does your child have tubes in his/hers ears now?
Yes No Are there any significant behaviors that may affect your child's performance in school or that be of concern?
Yes No Are there any specific cultural, social or religious patterns followed in the home that you would like to the school personnel to know about?
Yes No Would you like to discuss any of this health history with school personnel?

Please explain any "YES" answers and indicate the care for the illness (especially chronic illnesses and medications.)

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______________________________________ ______________________
Signature Date