



2018 STUDENT HEALTH HISTORY

Completed by a parent / guardian

Student Name: _____ **Date of Birth (month/day/year):** _____

Drug Allergies: _____ **No Known Drug Allergies**

Other Allergies: _____

Epi-pen: Yes / No Inhaler: Yes / No Please note that it is recommended that students bring two epi-pens and/or inhalers; one to have on them, one to store in Health Services.

Current Medications: _____

(in addition to listing here, please have prescriber fill out Medication Order form)

If your child is exempt from any vaccinations, please note which: _____

Does or has your child ever:	YES	NO	If yes, please explain and include dates
Had an ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
Had an allergic reaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a concussion or serious head injury?	<input type="checkbox"/>	<input type="checkbox"/>	
Lost consciousness or "passed out"?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a seizure/epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Been identified or treated for substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
Exhibited suicidal tendencies?	<input type="checkbox"/>	<input type="checkbox"/>	
Exhibited self-harming tendencies?	<input type="checkbox"/>	<input type="checkbox"/>	

Check all that apply to your child and provide details below:

- ADHD/ADD
- Anemia
- Anxiety
- Asthma (inhaler yes/no)
- Other: _____
- Chronic headaches/migraines
- Counseling
- Depression
- Eating/body image disorder
- Other: _____
- Severe menstrual cramps
- Seasonal allergies
- Sleep difficulties
- Stomachaches/digestive issues
- Other: _____

Notes on items checked above: _____

By signing this form, I verify that this information is true and complete, to the best of my knowledge.

Parent Signature: _____ **Date:** _____