 

Student Name Birthdate Grade

Health Care Provider (Please Print):

Health Care Provider Phone Number

Does your child have any activity restrictions? If yes, please explain:

List any daily medications, therapies, or treatments:

List all special equipment:

List date and type of major illness, accidents, injuries, and hospitalizations within the last year:

Is there anything else that you think we need to know about your child?

Parent/Guardian signature:

**Date:**

**Please complete both sides of this form. If more room is needed, please attach a separate sheet.**

 

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| --- | --- | --- | --- | --- | --- |
| **Health History in Past Year** | **NO** | **YES** | **Describe** | **Necessary Monitoring at School/Equipment** | **Medication** |
| Allergies Food?Insect Bites/Stings? Latex?Other?Date of Last Reaction: |  |  | Type of Reaction? |  |  |
| Asthma/Respiratory |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Traumatic Brain Injury |  |  |  |  |  |
| Seizures Type?Date of most recent? |  |  |  |  |  |
| Heart / Blood |  |  |  |  |  |
| Muscles/Bones/Joint/Skin |  |  |  |  |  |
| Bladder/Kidney/Spleen |  |  |  |  |  |
| Stomach/Intestines/Bowel |  |  |  |  |  |
| Immune |  |  |  |  |  |
| Hearing |  |  |  | Hearing Aids?Cochlear implant? |  |
| Vision |  |  |  | Glasses? Contacts?Reading only? |  |
| Other |  |  |  |  |  |