District 4 Student Health History Grade _____

Student Name:_____ Sex: _____ Race: _____ DOB: ____/____/____

Social Security #: _____-___-_____ Medicaid #: _____ Hospital Preference: _____

Family Doctor: _____ Phone:_____ Family Dentist: _____ Phone:_____

List all medications student takes, at home or at school: _____

Please check all that apply to your child. Provide necessary explanation in the comment area.

__ Asthma*****
__ Hay Fever
__ Allergies*****
__ Headaches
__ Skin Problems
__ Skeletal/Muscular Problems
__ Speech Problems
__ Kidney Problems
__ Nervous Stomach
__ High Blood Pressure
__ Eating Disorders
__ Insect stings __EPI pen*****
__ Blood Problems (anemia, sickle cell, hemophilia)
__ Ear Problems __tubes? __hearing aid?
__ Low Blood Sugar
__ Diabetes __ck at school? __injections? __pump?
__ Eye Problems __ glasses? __ contacts?
__ Seizures _____type _____date last seizure*****
__ Special diet

**** Please see the school nurse.***

Comments:_____

_____

_____

This form is maintained in your child's confidential health record so that in an emergency, school officials may have necessary critical information to provide emergency care. In the event parents cannot be located, school officials will take appropriate action deemed necessary in their judgment for the health of your child.

Parent Signature: _____ ***Date:*** _____