**STUDENT HEALTH HISTORY SCHOOL YEAR 2018-2019**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child take any medication on a regular basis? \_\_\_\_\_\_Yes \_\_\_\_\_\_No

 Medicine: \_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

 Medicine:\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

 Medicine: \_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_

 Medicine: \_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_

2. Does your child have allergies? \_\_\_\_Yes \_\_\_\_No, If yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does you child have activity restrictions? \_\_\_\_Yes \_\_\_\_No If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Does you child have any existing Health conditions? \_\_\_\_Yes \_\_\_\_No

 If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Does your child receive treatment, therapy or ongoing testing procedures?

 If yes, please explain, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any medical problems your child has had in the past:**

Asthma Dental Hospitalization/Surgery Premature Birth

Anemia Diabetes Learning differences Seizures

Arthritis Drug/Alcohol Lung disease Speech Difficulty

Behavior Eczema Lead Poisoning Tuberculosis

Blood Disorder Frequent Colds Meningitis Vision Problems

Cancer Hearing Difficulties Muscle/Bone/Joint Urination/Kidney

Heart/ Cardiac High Blood Pressure Physical Limitations

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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