Plateau Valley School District # 50
Health History
(to be completed by parent/guardian)

Student Name: _____ Date of Birth _____ Grade_____

Physician Name_____ Telephone #_____

Date of last physical exam_____
Overall health of student: o Excellent o Good o Poor(chronic health problems or issues)

Does your child take any medications on a regular basis? (Including medication for asthma or ADHD):

o At Home o Needs to take at school

Medication(s): _____

Time(s) given:_____

Reason for taking medication: _____

ALLERGIES
Allergies to Medications: _____

Environmental Allergies: _____

Food Allergies: _____

Medical History (Please mark all that apply)

o Frequent Headaches	o Frequent colds	o Asthma
o Seizures	o Diabetes	o Anemia
o Frequent ear infections	o Frequent Strep Throat	o Rheumatic fever
o Hayfever/Seasonal Allergies	o Meningitis	o German Measles
o Vision problems	o Liver Disease	o Measles
o Wears glasses or contacts	o Kidney disease	o Chicken Pox
o Hearing problems	o Heart problems	When? _____
o Wears hearing aids	o Skin rashes/hives/eczema	o ADD/ADHD
o Pneumonia (RSV, Whooping Cough, other severe respiratory illness)		o Autism/Aspergers

o Other health problems or chronic health concerns:
_____

Any physical limitations or need special equipment? o Yes o No
If yes, please describe: _____

_____

Past hospitalization/surgeries? o Yes o No
If yes, please describe and include dates:

_____

_____

Parent/Guardian Signature **Date**