HEALTH HISTORY

Student Name: _____
Last First Middle

Mailing Address: _____

Father's Name: _____ Mother's Name: _____
Last First Last First

Student Resides With:
_____ Telephone: _____
Name/Relationship to Student

Family Physician Name: _____ Telephone: _____

Is your child at present under Medical Treatment? YES NO

If yes, please explain:
_____
_____

List any additional illness you or your family physician feel should be known:
_____
_____

Special Comments:
_____

Has your child had any childhood illness? Please list, giving dates and complications:
_____
_____

Does your child have, or has he/she had: (Check all that apply)

☐.....Vision Loss
☐.....Eye Disease
☐.....If yes, does your child wear glasses or contacts
☐.....Hearing Loss
☐.....If yes, does your child wear a hearing aid
☐.....Earaches
☐.....Convulsions
☐.....Epileptic Seizures
☐.....Asthma
☐.....Head Injury
☐.....Headaches
☐.....Diabetes
☐.....Is your child receiving dental care

(OVER)

Is your child currently taking any long term medication? YES NO
If yes, explain:
_____
_____

Has your child had any of the following: (give date and details)

Allergy:_____

Recurring Illness: _____

Serious accidents: _____

Emotional problems: _____

Recent loss of loved one or pet:_____

Parent Signature: _____ Date: _____