Health History
(Preschool through Sixth Grade)

Student Name:_____ Date of Birth:_____ Sex: M ☐ F ☐

Parent/Guardian Name:_____ Address:_____

Parent/Guardian Telephone:_____ Date:_____

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's safety and educational success. Please contact the school nurse if you have questions. Return the completed form to the school health office.

A. Current Health Status

1. Does your child take medicine or supplements regularly? ☐ No ☐ Yes
   Please list:

2. Has your child recently been diagnosed with a condition (either physical or mental health) and is undergoing treatment? ☐ No ☐ Yes
   Please list conditions and treatments:

3. Does your child have allergies? ☐ No ☐ Yes
   Please list:

4. Date of last medical exam_____

5. Date of last dental exam_____

6. Does your child have current health insurance coverage? ☐ No ☐ Yes

7. Would you like more information about the state health insurance program? ☐ No ☐ Yes

B. Check conditions your child has experienced

☐ Asthma	☐ Eczema	☐ Recurrent headaches
☐ Balance and coordination problems	☐ Headaches (including migraines)	☐ Respiratory illness/conditions
☐ Bleeding disorders	☐ Head trauma or concussion	☐ Rhuematic fever
☐ Broken bones	☐ Heart problems	☐ Severe food allergies
☐ Chicken pox	☐ Kidney problems/urinary problems	☐ Sleeping problem
☐ Convulsions or seizures	☐ Loss of consciousness	☐ Tires easily
☐ Diabetes	☐ Nosebleeds	☐ Vision/hearing

If you checked any of the above, please describe: