EMBED MSPhotoEd.3

STUDENT HEALTH HISTORY FORM

Student Name: ____ Grade/Age:

Family Medical Insurance:

Full Term Pregnancy: ____ Yes ____ No Birth Weight: _______________

Complications During Pregnancy/Birth:

Family Doctor: ____ Phone:

Family Dentist: ____ Phone:

Serious Injuries, Operations, Illnesses including Dates:

Asthma: ____ Yes ____ No Medication Required:

Does student have or ever had:

	YES/Dates		YES/Dates
Chicken Pox	☐ __________	Contact W/Tuberculosis	☐
Measles	☐ __________	Rheumatic Fever	☐
Mumps	☐ __________	Diabetes	☐
Scarlet Fever	☐ __________	Hepatitis	☐
Whooping Cough	☐ __________	Pneumonia	☐
Allergies	☐ __________	Heart Disease	☐
Frequent Cold/Sore Throat	☐ __________	High Fevers	☐
Frequent Earaches (which ear)	☐ __________	Seizures	☐

If YES, Please Provide Details:

Does student have or ever had a problem related to:

YES/Dates YES/Dates

Vision:	☐ ________	Headaches	☐
Dental	☐ ________	Orthopedic	☐
Neurological	☐ ________	Emotional	☐

If YES, Please Provide Details:

YES	NO	
☐	☐	Has student ever passed out during exercise or stopped due to dizziness?
☐	☐	Does student have asthma (wheezing), hay fever or coughing spells after exercise?
☐	☐	Has the student ever broken a bone, had to wear a cast or had any injury to any joint?
☐	☐	Has the student ever had a concussion or been knocked unconscious?
☐	☐	Has the student ever suffered heat related illness (Heat Stroke)?
☐	☐	Does the student have a chronic illness or see a physician regularly for any particular problems?
☐	☐	Does the student take any medication?
☐	☐	Is the student allergic to any medications, bee stings or foods?
☐	☐	Has the student missed 5 consecutive days of school, phys. Ed. Or sports due to injury or illness?
☐	☐	Does the student wear glasses/contact lenses?
☐	☐	Has the student ever been hospitalized or had surgery?
☐	☐	Does the student live with anyone who is immunosuppressed or suffering from a chronic illness?
☐	☐	Do you have anything you would like to discuss with the school nurse?

If YES, Please Provide Details:

Parent Signature/Phones: ____ Date: