



CONFIDENTIAL STUDENT HEALTH HISTORY

To be completed by parent/guardian

Student Name (Last, First, Middle)	Birth Date: _____ Mo _____ Day _____ Yr	Race	Sex M F
------------------------------------	--	------	---------------------------------

Address (Number, Street, City, State, Zip)

Parent/Guardian Names:

Where do you usually take your child for medical care? Phone No.
Name: _____ Address: _____

When was the last time your child had well child health assessment?
Month: _____ Year: _____

Where do you usually take your child for dental care: Phone No.
Name: _____ Address: _____

Does your child use Fluoride Toothpaste? YES NO **DATE OF LAST DENTAL VISIT:** _____
Does your child have dental cavities? YES NO
What is your source of drinking water? **CHECK ALL THAT APPLY:** Public Water Well/Cistern Bottle Water _____

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have a history of or any problems with the following? Please check yes or no and DESCRIBE

	Yes	No	DESCRIBE
Does your child have a physical handicap?			
Does your child have a behavioral or emotional problem?			
Does your child have a learning problem?			
Hospitalization-over night?			Why, When, Where?
Concussion (Head Injury)			Date-Over night in hospital?
Surgery?			Reason
Lead Poisoning?			Treatment?
Eye or Vision Problems?			Eyeglasses?
Diet/Eating Problem/Weight Problem?			
Diabetes?			
Ear Problems?			Infections? Hearing Loss?
Speech Problems?			Speech Therapy?
Heart Problems?			Limited exercise? Medications? Need prophylactic antibiotics for dental visits?
Allergies (Food, Insects, Drugs, etc.)? Peanut, Egg, Milk, Citrus? Bee? Penicillin?			List and Describe Reaction
Asthma?			Required Emergency Department Visit?
Sickle Cell Diseases?			If Yes, Has child received Pneumococcal vaccine? _____ Meningococcal vaccine? _____ Takes Penicillin daily?
Seizures?			Medication?
Bleeding Problems?			
Limits on Activity?			Reason?
Problems with Bladder/Bowels?			
Receives Annual Flu Vaccine?			
Do you feel your child has any other health problem not mentioned above?			Describe

Does your child take any medications? Yes No

Name of Medication(s) and Dose _____

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____