



CONFIDENTIAL STUDENT HEALTH HISTORY

To be completed by parent/guardian

Student Name (Last, First, Middle)	Birth Date ____ Mo ____ Day ____ Yr	Sex M F	School	Grade
Address (Number, Street, City, State, Zip)				
Parent/Guardian Names:				
Where do you usually take your child for medical care? Name: _____ Address: _____			Phone No. _____	
When was the last time your child had a physical exam? Month: _____ Year: _____				
Where do you usually take your child for dental care? Name: _____ Address: _____			Phone No. _____	
Birth History: Birth Weight _____ Number of Days Baby in Hospital _____				
Complications _____				
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.				
	Yes	No		
Birth Defects				
Prematurity				
Hospitalization (When, Where)				
Concussion (Head Injury)				
Surgery				
Lead Poisoning				
Eye or Vision Problems				
Ear Problems				
Speech Problems				
Cerebral Palsy				
Meningitis				
Heart Problems				
Serious Allergic Reactions				
Behavior or Emotional Problem				
Allergies (food, Insects, Drugs, etc)				
Asthma				
Sickle Cell Diseases				
Seizures				
Bleeding Problems				
Limits on Activity				
Problems with Bladder				
Problem with Bowels				
Other (Please list)				
School Immunization Record DHMH Form 896				
Does your child take any medications? ____ Yes ____ No Name of Medication(s) _____				
Parent/Guardian Signature:			Date:	