**STUDENT HEALTH HISTORY UPDATE**

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| --- | --- | --- |
| Name:  | DOB: Age:Grade: | Gender: 🞎 M 🞎 F |
| Parent/Guardian:(person completing this form) | Home Phone: Cell Phone: | Date:  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Has your child ever:** | **YES** | **NO** | **If Yes, please explain and include date:** |
|  Had an ongoing medical condition | 🞎 | 🞎 |  |
|  Seen a medical specialist | 🞎 | 🞎 |  |
|  Had allergies:  | 🞎 | 🞎 | 🞎food 🞎environmental 🞎insect 🞎medication 🞎other  |
|  Been hospitalization | 🞎 | 🞎 |  |
|  Had an operation | 🞎 | 🞎 |  |
|  Had an injury requiring an Emergency Room visit | 🞎 | 🞎 |  |
|  Missed 5 days of school in a row due to illness/injury | 🞎 | 🞎 |  |
|  Had a bone/muscle injury | 🞎 | 🞎 |  |
|  Passed out, had a concussion or serious head injury | 🞎 | 🞎 |  |
|  Had a convulsion/seizure | 🞎 | 🞎 |  |
|  Had a vision problem or condition | 🞎 | 🞎 |  🞎 glasses 🞎 contacts |
|  Had a hearing problem or condition | 🞎 | 🞎 |  🞎 hearing aid 🞎 cochlear implant |
|  Worn dental bridge, braces or mouthpiece | 🞎 | 🞎 |  |
| **Have any family members under the age of 50 ever**: | **YES** | **NO** | **If Yes, please specify:** |
|  Had a heart attack | 🞎 | 🞎 |  |
|  Had other serious health problems | 🞎 | 🞎 |  |

**CHECK ALL THAT APPLY TO YOUR CHILD:**

🞎 ADHD

🞎 Asthma/trouble breathing

🞎 Autism/Asperger

🞎 Dental Injuries

🞎 Diabetes

🞎 Ear Infections

 🞎 GI Conditions (ulcer, reflux, IBS)

🞎 Headaches/migraines

🞎 Heart Conditions

🞎 High Blood Pressure

🞎 Mental Health Condition

 (depression, eating disorder, anxiety, OCD, ODD, etc.)

🞎 Scoliosis

🞎 Single Organ (🞎kidney, 🞎testicle)

🞎 Skin Condition

🞎 Speech Condition

🞎 Urinary Condition

|  |  |  |  |
| --- | --- | --- | --- |
| **CURRENT MEDICATIONS** | **YES** | **NO** | **Please list name, dose, time(s)** |
| Given at school | 🞎 | 🞎 |  |
| Taken at home | 🞎 | 🞎 |  |
| **ASSISTIVE EQUIPMENT** | **YES** | **NO** | **Please check all that apply** |
| During or outside of school | 🞎 | 🞎 | 🞎crutches 🞎walker 🞎wheelchair 🞎other:  |
| **TREATMENTS** | **YES** | **NO** |  |
| During or outside of school | 🞎 | 🞎 | 🞎insulin/blood glucose monitoring 🞎inhaler/nebulizer/peak flow monitoring 🞎special diet  |

Is there any condition that would prevent your child from participating in physical education or sports?

🞎 No 🞎 Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_