STUDENT HEALTH HISTORY UPDATE

NAME: _____ GRADE: _____ TEACHER: _____

SEX: M___ F____ SCHOOL: _____ TRANSFER FROM: _____

PARENT [ ] GUARDIAN [ ] _____

MAILING ADDRESS: _____

PRESENT DOCTOR OR HEALTH CARE FACILITY: _____

PLEASE ANSWER ALL QUESTIONS LISTED BELOW:

1. Does your child have any of the following?

Asthma [ ]	Orthopedic (Bone) Problems [ ]
Diabetes [ ]	Heart Disease [ ]
Epilepsy/Seizures [ ]	Heart Murmur [ ]
Kidney Problems [ ]	Headaches [ ]
Bleeding Problem [ ]	

Please explain any problems checked:

_____

_____

2. Does your child have severe allergies (medicine, food, insect bites) Yes [ ] No [ ]

If yes, list them and describe what happens to the child_____

_____

Does child take medicine for allergic reaction? Yes [ ] No [ ]

If yes, please list medicine and if it will be sent to the school for us to keep for child to use if necessary

_____

3. Has your child had any illnesses since school closed in June Yes [ ] No [ ]

4. Has your child had surgery since school closed last year? Yes [ ] No [ ]

If yes, list surgery and date _____