STUDENT HEALTH HISTORY UPDATE

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)_____
_____

Parent/Guardian Signature:_____Date:_____