Student Health History Form

Tri Village Local School District

This information is needed in order to plan adequately to meet the needs of your child.
To be completed by parent/guardian

Child's Name: ____
Last *First* *Middle*

Birth Date: ______________________ ( ) Male ( ) Female Grade: __________________

Child's Health History (Please Check any of the following that pertain to your child):

( ) Heart problems
( ) Sore throat (over 3 per year)
( ) Cerebral palsy
( ) Asthma
( ) Nosebleeds
( ) PKU
( ) Hyperactivity
( ) Dental Problems
( ) Spina bifida
( ) Convulsions
( ) Skin Condition
( ) Cystic fibrosis
( ) Eye problems
( ) Urinary frequency
( ) Other________________
( ) Earaches (over 3 per year)
( ) Diabetes

If any problems are checked above, please explain: ____
____

Has your child had chicken pox? Please list approximate month and year: ________________________________

Does your child have allergies? ( ) No ( ) Yes

Environmental ____
Medicine ____
Foods ____
Family history of allergies ____

Does anyone in your family have hepatitis or tuberculosis? ( ) No ( ) Yes

Please check if your child wears: ( ) Glasses ( ) Hearing Aid ( ) Braces
( ) Artificial Limb ( ) Other ___________________________________

Has your child ever been hospitalized? Why and Date(s): ____
____

Has your child ever had surgery? ( ) No ( ) Yes Type and Date(s):________________________________
____

Does your child take prescription medication(s)? ( ) No ( ) Yes If yes, please explain: ________________
____

Was your child born prematurely or were there any complications during pregnancy or delivery that may affect the child at school? ( ) No ( ) YesIf yes, please explain: ___________________________________
____

If there are any special health considerations the school should be aware of concerning your child, please explain: ____
____

Person giving above information: ____
Name *Relationship to Child*

____
Signature of person filling out this form *Date*