

# STUDENT HEALTH HISTORY UPDATE

*This information will be shared with staff and administration on a need to know basis unless you notify us otherwise.*

Date \_\_\_\_\_ Parent / Guardian's Signature \_\_\_\_\_

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

**PLEASE CHECK IF YOU CHILD HAS OR HAS HAD ANY OF THE FOLLOWING.  
GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.**

1.     ADD / ADHD                       Body Piercing / Tattoo     Emotional issues                       Physical Disability  
       Allergies                               Bone Problems                       Hearing difficulties                       Seizures  
       Asthma                                   Bowel / Bladder                       Heart conditions                       Speech difficulties  
       Behavior issues                       Chicken Pox                           Infections                               Surgery  
       Bleeding disorders                       Diabetes                                   Kidney disorders                       Vision difficulties  
       OTHER \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

2.    Does your child have allergies to medicine, food, latex or insect bites? Yes ( ) No ( )  
      To What \_\_\_\_\_ What Happens \_\_\_\_\_  
      Treatments \_\_\_\_\_

3.    Has your child had any illnesses or general health concerns in the last 12 months? \_\_\_\_\_  
      Did your child see a doctor for this or receive medication? Yes ( ) No ( )  
      Comments \_\_\_\_\_

4.    Has your child had surgery in the last 12 months? Yes ( ) No ( )  
      Comments \_\_\_\_\_

5.    Does your child take **any** medications – prescriptions or over the counter on a regular basis?  
      Name of medication, dose, and when taken \_\_\_\_\_  
      \_\_\_\_\_ Will these medications be taken during school hours? \_\_\_\_\_  
      When was your child last seen by the doctor concerning these medications? \_\_\_\_\_

6.    Does your child receive any treatments? \_\_\_\_\_ For? \_\_\_\_\_

7.    When was your child's last physical (including immunization review)? \_\_\_\_\_  
      DIAA Sports form completed (if playing sports) Yes ( ) No ( )  
      Name of doctor? \_\_\_\_\_

8.    Has your child had any emotional upsets in the past 12 months (death, separation, divorce recent move) Yes ( ) No ( ) Is you child receiving counseling? Yes ( ) No ( )  
      Comments: \_\_\_\_\_

9.    Does your child wear corrective lenses? Yes ( ) No ( ) Date of last exam \_\_\_\_\_  
      Name of doctor? \_\_\_\_\_

10.   Does your child have any dental problems? Yes ( ) No ( ) Date of last exam \_\_\_\_\_  
      Name of doctor? \_\_\_\_\_

**PLEASE USE THE BACK OF THIS FORM FOR ADDITIONAL SPACE OR CONCERNS.**

