STUDENT HEALTH INFORMATION
(To be completed by parent/guardian)

Date__________________

Student's Name_______________________ Birthdate_____________ Age/Grade_____________

Parent/Guardian______________________________ Address_____________________________

School___________________ Phone #1__________________ Phone #2___________________

Family Physician______________________________ Family Dentist________________________

HEALTH HISTORY

1. Does your child have any health conditions? Yes___ No___
   (if so, please explain)

2. Does your child have allergies or food intolerance? Yes___ No___
   (if so, please explain)

3. Has your child experienced any serious illnesses, accidents, injuries, or surgeries? (if so, please explain) Yes___ No___

4. Is your child taking a daily medication? Yes___ No___
   (if so, list medication(s) and reason(s)

5. Is your child taking PRN (as needed) medication? Yes___ No___
   (if so, list medication(s) and reasons(s)

6. Do you have any concerns about your child's behavior? Yes___ No___
   (if so, please explain)

DEVELOPMENTAL HISTORY

Do you have any concerns about your child's growth or development? Yes___ No___
(if so, please explain)

(over)

VISION HISTORY

Has your child experienced any difficulties with vision? Yes___ No___

Has your child ever had a professional vision exam? Yes___ No___ Doctor:________________

Date________ Results________________

HEARING HISTORY

Has your child been treated medically or surgically for ear problems or frequent ear infections? Yes___ No___

Was your child treated by an ear specialist? Yes___ No___

Name of specialist___________________________________

Hearing results_____________________________________

SPEECH

Do you think your child's speech and language development is appropriate for his/her age? Yes___ No___

Is there any information about your child that would be helpful to school personnel in working with your child?

The above information is accurate and complete and may be used by school district personnel for educational purposes of my child.

______________________________________ Parent/Guardian Signature

______________________ Date

Please remember to complete and return the yellow immunization card.

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