HEALTH HISTORY

(Filled out by a Parent/Guardian)

Date of Birth _____ Gender **F** ☐ **M** ☐ Grade _____

Student's Name _____ Phone _____
Last First MI

Address _____ Place of Birth _____

_____

Parent and/or Guardian _____

Previous School/Nursery School _____

Student's Physician _____ Dentist _____

Eye Problems _____ Ophthalmologist _____

Wears Glasses _____ Optometrist _____

Ear Problems _____ Tubes _____ Physician _____

Has History of: (check all that apply - explain below)

Allergies	☐	Pneumonia	☐
Anemia	☐	Scarlet Fever	☐
Asthma	☐	Rheumatic Fever	☐
Bronchitis	☐	Epilepsy	☐
Chickenpox	☐	Operations	☐
Diabetes	☐	Kidney Problems	☐
Heart Disease	☐	Sickle Cell Anemia	☐
Hepatitis	☐	High Blood Pressure	☐
Meningitis	☐	Orthopedic	☐
Mononucleosis	☐	Fractures	☐

USE THE SPACE BELOW TO EXPLAIN AREAS CHECKED ABOVE:

_____

_____

_____

Parent/Guardian Signature _____ Date _____