STUDENT HEALTH HISTORY

Name:_____ Date:_____

Allergy, specify:_____ Diabetes (date of onset):_____ Epilepsy (date of onset):_____

Under M.D. treatment?_____ Asthma:_____ Ear infections:_____

Speech therapy recommended: Yes / No Dates received:_____

Congenital defects, such as cleft lip, cleft palate etc._____, _____, _____

Ear tubes (year inserted)_____ Injuries:_____, _____, _____

Surgery?_____ Type/Dates:_____, _____, _____, _____

Heart Condition, specify:_____

_____

_____

Other:_____

_____

_____

Significant Family Health History, diabetes, tuberculosis, etc._____

_____

_____

Physical restrictions or health problems that may require special seating, bathroom privileges, etc._____

_____

_____

Special diet or food restrictions:_____

_____

_____

Current medications – What? How often?_____

_____

_____

Any other information regarding your child's health or well-being, that you feel would be helpful._____

_____

_____