

HISTORY OF HEALTH

Student's Name: _____ Birthdate: _____ Date: _____

The safety and well-being of your child is important to us. Many physical or emotional problems may interfere with a child's ability to learn. We can assist your child with the task of learning if we are aware of any possible health problems.

HEALTH PROBLEMS (Check all that apply)

Diagnosed ADD or ADHD.....	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	
Bladder Problems	<input type="checkbox"/>	
Bleeding Disorder	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	Date of illness _____
Color Vision Deficiency.....	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Eczema/Skin Trouble.....	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	
Eye Injury.....	<input type="checkbox"/>	
Frequent Nosebleeds.....	<input type="checkbox"/>	
History of Ear Problem	<input type="checkbox"/>	Describe _____
Heart Problem	<input type="checkbox"/>	Describe _____
Head Injury.....	<input type="checkbox"/>	Describe _____
History of Fractures	<input type="checkbox"/>	Describe _____
History of Hospitalization.....	<input type="checkbox"/>	Describe _____
History of Surgery	<input type="checkbox"/>	Describe _____
Hypoglycemia	<input type="checkbox"/>	
Known Hearing Loss.....	<input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Known Vision Loss	<input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Measels (German)	<input type="checkbox"/>	Date of illness _____
Measels (Red)	<input type="checkbox"/>	Date of illness _____
Mumps	<input type="checkbox"/>	Date of illness _____
Physical Limitations.....	<input type="checkbox"/>	Describe _____
Pneumonia	<input type="checkbox"/>	Date of illness _____
Scoliosis.....	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	
Speech Problems	<input type="checkbox"/>	
Tonsillitis	<input type="checkbox"/>	Date of illness _____
Wears Contact Lenses.....	<input type="checkbox"/>	
Wears Glasses.....	<input type="checkbox"/>	For close work <input type="checkbox"/> For distance only <input type="checkbox"/> At all times <input type="checkbox"/>
Other or further details of above _____		

The Lemon Grove School District prohibits discrimination, harassment, intimidation, and bullying, based on actual or perceived race, color, ancestry, national origin, nationality, ethnicity, ethnic group identification, age, religion, marital or parental status, physical or mental disability, sex, sexual orientation, gender, gender identity, or gender expression; or association with a person or group with one or more of these actual or perceived characteristics, at any district school or school activity. Title IX Coordinator Edward Caballero ecaballero@lemongrovesd.net 619-825-5728. Equity Compliance Officer Dr. Yolanda Rogers yrogers@lemongrovesd.net 619-825-5712

HISTORY OF HEALTH (continued)

Any limitations on school activities _____

ALLERGIES (Check all that apply) NONE:

- Animals Drugs
 Insects Food
 Bee Stings Plants
 Other

List specific item(s) student is allergic to _____

Describe allergic reaction and/or treatment _____

CURRENT MEDICATION(S)

Name of Medication(s)	Dosage	Time Taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

Date of last medical examination _____ Doctor _____

Date of last dental examination _____ Doctor _____

Date of last eye examination _____ Doctor _____

If you would like to discuss any health problems of your child with the School Nurse or Health Clerk, please list your name and daytime phone number:

Name _____

Phone _____

Signature of Parent/Guardian _____ Date _____

03/2019.LGSDHealthHistory

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