Lemon Grove SCHOOL DISTRICT

8025 Lincoln Street · Lemon Grove, CA 91945
P | 619-825-5600 · F | 619-462-7959
lemongrovesd.net

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

_____

_____

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HISTORY OF HEALTH (continued)

Any limitations on school activities _____

_____

ALLERGIES (Check all that apply) NONE: ☐

Animals ..... ☐
Insects ..... ☐
Bee Stings..... ☐
Drugs ..... ☐
Food ..... ☐
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