STUDENT HEALTH HISTORY FORM

Name____________________________ **School** _____________ **Male/Female**_____ **Date of Birth**____________
Address____
Telephone_____________________ **Work Phone**____
Parent/Guardian___________________________ _______________________________
Emergency Contact________________________ **Phone**________________ **Relation to student** _____________

Please check **yes** or **no** for any of the following health problems this student has or has ever had in the past:

Illness	Yes	No	Medication	Comments
Attention deficit disorder (ADHD/ADD)				
Allergies/Anaphylaxis				
Asthma				
Birth defects				
Seizures				
Depression/Anxiety				
Diabetes				
Fainting spells				
Heart problems (specify)				
Migraines				
Hearing loss				
High blood pressure				
Skin problems				
Stomach problems				
Vision problems				
Injury from accident				
Bladder problems				
Bone/Joint problems				
Other				

Student's doctor(s)/healthcare provider(s) & Phone Number:____
____
____
Past surgeries and hospitalizations:____
Parent Signature____ **Date**___________________________