

STUDENT HEALTH INFORMATION SHEET

Student's name \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ DOB \_\_\_\_\_

Family doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Does student suffer from frequent: colds \_\_\_\_\_ sore throats \_\_\_\_\_ earaches \_\_\_\_\_

headaches \_\_\_\_\_ nosebleeds \_\_\_\_\_ fainting spells \_\_\_\_\_ allergies \_\_\_\_\_

food allergies \_\_\_\_\_ list: \_\_\_\_\_

asthma \_\_\_\_\_ seizures \_\_\_\_\_ heart condition \_\_\_\_\_ diabetes \_\_\_\_\_

pneumonia \_\_\_\_\_ other health problems \_\_\_\_\_

Has student ever had any: surgeries \_\_\_\_\_ fractures \_\_\_\_\_

any other injuries \_\_\_\_\_

Has student ever had chicken pox \_\_\_\_\_ If yes, date \_\_\_\_\_

**MUST HAVE AT LEAST THE MONTH AND YEAR TO BE EXEMPT FROM SHOT**

Does student wear glasses or contact lenses \_\_\_\_\_

Does student have a known speech problem \_\_\_\_\_

Does student have a hearing problem \_\_\_\_\_

Does student have any restrictions due to illness or health status \_\_\_\_\_ If yes, list:

\_\_\_\_\_

List any medications the student takes either at school or at home on a daily basis and the reason for giving: \_\_\_\_\_

\_\_\_\_\_

Is student allergic to any medication \_\_\_\_\_ list: \_\_\_\_\_

Describe any other health condition your student may have or give any information you feel is pertinent to your student's health record \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

(please sign and return)