WARROAD PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

Student Name: Date of Birth: Grade:

Please read both sides of this form and check any illness or conditions your child has or has had. Please explain each under "Comments".

____ ADHD Medication: Yes___ No___

____ Allergy: ____Bee Sting
____Food (explain)
_____
____Medication (explain)
_____
____Other (explain)
_____
____Epi-pen Required: Yes___ No___

____ Anemia
____ Arthritis
____ Asthma: Inhaler Yes___ No___
____ Birth Defect/Chromosome Disorder
____ Blood Disorder
____ Cancer/Leukemia
____ Cerebral Palsy
____ Chickenpox
____ Color Blindness
____ Cystic Fibrosis
____ Depression
____ Diabetic: Insulin Dependent: Yes___ No___
____ Ear Infections: PE Tubes: Yes___ No___
____ Eating Disorders: Under/Overweight
____ Endocrine Disorders
____ Epilepsy/Seizures: Medication Yes___ No____
____ Growth Disorder
____ Hearing Loss: Right ear___ Left Ear___
____ Hearing Aid Used
____ Heart Disease/Defect
____ Hemophilia
____ Kidney disorder

PLEASE COMPLETE BOTH SIDES OF THIS FORM

____ Medication Prescribed (Please explain under "Comments")

____ Medication Needed at School (Please explain under "Comments")

____ Menstrual Cramps

____ Mental Health Condition

____ Migraine Headaches

____ Muscular Dystrophy

____ Nose Bleeds (frequent)

____ Osgood-Schlatter Disease

____ Physical Activity Limitations (Requires a Doctor's note)

____ Rheumatic Fever History

____ Scoliosis

____ Sickle Cell Anemia

____ Tuberculosis

____ Ulcer

____ Urinary Tract Infections

____ Vision Impairment - Wears: ____glasses ____contacts

____ Vision Impairment (Visually handicapped)

____ Other: _____

_____

_____

____ No Known Health Problems

Comments: _____

_____

_____

_____

_____

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_____

Parent Signature:_____ Date:_____