

# 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: \_\_\_\_\_