



# Student Health History

School year \_\_\_\_\_

The school requires that this form be completed by the student's parent **annually** to ensure that we understand your child's health care needs. All students will receive emergency treatment unless otherwise specifically requested. Please submit this form with your admission or return it to the infirmary **by the first day of the school year**.

**Student's Name:** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Last** \_\_\_\_\_ **First** \_\_\_\_\_ **Middle** \_\_\_\_\_  
M/D/Y **Age** \_\_\_\_\_ **Entering Grade** \_\_\_\_\_

Home Phone \_\_\_\_\_

Emergency contact information (other than parents)

Father's Phone \_\_\_\_\_

Name/relationship \_\_\_\_\_

Mother's Phone \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_

## Disease History

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Allergies - medicines \_\_\_\_\_

Major surgery/Accidents \_\_\_\_\_

- food \_\_\_\_\_

Congenital anomalies \_\_\_\_\_

- other \_\_\_\_\_

ADD/ADHD \_\_\_\_\_

Epilepsy \_\_\_\_\_

Infectious diseases \_\_\_\_\_

Heart disease \_\_\_\_\_

Significant weight loss or gain \_\_\_\_\_

Others \_\_\_\_\_

List **Medications/ Physical Limitations/ Concerns/ Descriptions** (if any):

\_\_\_\_\_  
\_\_\_\_\_

**Permission to dispense TYLENOL** (acetaminophen): YES / NO

Tylenol is used as treatment of mild to moderate pain and fever. Parents of elementary students and kindergarten will be contacted if medication is dispensed.

**Prefer to give IBUPROFEN** for Junior High/High student: YES / NO

For **Returning students**: Immunization Records are Current YES / NO Reason \_\_\_\_\_

For **New Students** or **any changes** please complete the following:

**Immunizations** (list dates, M/D/Y)

D.P.T. (Diphtheria/ Pertusis/Tetanus) 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Tetanus/ Diphtheria Booster \_\_\_\_\_

Polio 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

MMR (Measles/Mumps/Rubella) 1. \_\_\_\_\_ 2. \_\_\_\_\_

Measles \_\_\_\_\_

Mumps \_\_\_\_\_

Rubella (3-Day or German Measles) \_\_\_\_\_

Rubeola (Red Measles) \_\_\_\_\_

BCG \_\_\_\_\_

Tuberculosis test (date/result) \_\_\_\_\_

Others \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_