

Student Health History

Full Name _____

Male _____ Female _____ Date of Birth _____ Grade _____

Present Address _____

Parent/Guardian _____

Home Phone (____)-____-____ Work Phone (____)-____-____

Cell Phone (____)-____-____

Medical History

Operations _____

Emotional Problems (Hysteria, Depression, etc.)

Serious Medical Problems _____

Contact lenses or other prosthetic devices

Diabetes: Yes No Epilepsy: Yes No Asthma: Yes No

Last Tetanus Injection: _____

Allergies: _____

Medications now taking Do You use an Inhaler: Yes No

Will the child be taking them on his/her own? _____

Please list any special Medical considerations that a doctor should be aware of in the event of an
emergency? _____

Family Physician: _____ Phone #: (____) - _____ - _____

To the best of my knowledge, all of the above information is true and accurate.

Signature of Parent / Guardian

Date