

# School Health History Update

Student's Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Does your child have any of the following health problems?

	No	Yes - please explain
Allergies		
Chronic health problems (diabetes, asthma, epilepsy, etc)		
Problems with their: Heart or blood		
Lungs		
Bowels		
Bowels/Kidney		
Eyes/Ears		
Nose/Throat		
Skin		
Muscle/Bones		
Nervous System		
Immune System		
Restrictions in diet		
Restrictions in activity		

Is your child under the care of a Physician? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, for what reason? \_\_\_\_\_

Is your child on medication? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, what medication? \_\_\_\_\_

Do you have any concerns regarding your child's health? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please explain: \_\_\_\_\_