

HEALTH HISTORY

(To be filled out and signed by **parent**)

Has your child _____ ever had or now have:

Yes	No	(Check each item
		Allergy
		Anemia
		Arthritis
		Asthma
		Chicken Pox
		Concussion
		Diabetes
		Eczema
		Emotional problems
		Epilepsy

Yes	No	(Check each item
		Fainting
		Hearth murmur
		Hepatitis
		Hernia
		Hives
		Kidney trouble
		Measles
		Menstrual cramps (severe)
		Migraine headache
		Mononucleosis

Yes	No	(Check each item
		Mumps
		Pneumonia
		Polio
		Rheumatic fever
		Sinus trouble (severe)
		Sore throat (severe)
		Tuberculosis
		Valley Fever
		Whooping cough
		Other

Operations _____

Nature

Year

Nature

Year

Fractures _____

Nature

Year

Nature

Year

Sprains or Dislocations _____

Nature

Year

Nature

Year

If student has had prolonged absences from school, state why and when _____

To which medicines is student allergic _____

If student is now under medical treatment, why and the doctor's name _____

Sports from which student is to be excluded _____

Date of last: Tetanus booster: _____ Chest x-ray _____

If emergency service involving medical action or treatment is required and neither the parents or guardians can be contacted I hereby consent for the student named above to be given medical care by the doctor selected by the school.

Signature of Parent or Guardian _____ Phone _____

Name of family Physician _____ Address _____ Phone _____