Student Health Information Form

Name: ______________________________ Gender: _____ Date of Birth: _________________

Pediatrician/Primary Health Care Provider:

Name: _________________________________ Phone Number: ___________________

Please list **medications** that your student takes:

____

To the best of your knowledge, has your student had any of the following **health concerns**?

	Yes	No	If yes, describe:
Prematurity			
Birth defect			
Immunity problems			
Bleeding problems			
Lead poisoning			
Sickle Cell Disease			
Diabetes			
Anaphylaxis			
Seasonal allergies			
Food allergies			
Behavior/emotional problems like ADHD, Anxiety, Depression			
Concussion or traumatic brain injury			
Migraines			
Learning problems/disabilities			
Seizures			
Speech problems			
Ear or hearing problems			
Eye or vision problems			
Dental problems			
Asthma or breathing problems			
Heart problems			
Stomach problems			
Bowel problems			
Bladder problems			
Musculoskeletal problems			
Limited physical activity			

Hospitalizations:

Date(s)	Reason(s)

Surgeries:

Date(s)	Reason(s)

Date of last tetanus vaccination: ___________________________

Please note that your student must have documentation of a current *tetanus vaccination* and complete *physical examination* on file with the school nurse prior to June 1, 2019. This physical examination must be dated on or after April 1, 2018.

Parent Name: ____

Parent Signature: ____ Date: ____________________