Student Health History

Student's Name_____ Birth Date_____ Sex: M__F__

Home Telephone _____ Cell phone_____

Significant Medical Conditions? if answering "yes", please explain:

	Yes	No	Explain
ADHD/ADD			
Allergy to food			Require EpiPen? ____
Allergy to insect (bee) sting			Require EpiPen? ____
Arthritis			
Asthma			Require Inhaler? ____
Autism/Asperger's			
Cardiac			
Developmental Delay/PDD			
Diabetes			
Emotional/Behavioral			
Gastrointestinal			
Hearing			Hearing aid(s)? ____
Orthopedic			
Seizures			
Skin			
Speech			
Urinary			
Vision			Glasses(?) _____
Other			

Please list family members currently living in your home and note any special relationship such as grandparent, stepparent, adopted, foster, etc.:

Mother_____

Father_____

Brother(s)/Sister(s), please list names and ages:

_____

_____

Are there any special conditions which require restriction of activity or medication that might affect your child's education? If so, please explain:

_____

Please list any past operations, accidents or concussions:

_____

Please list all current medication(s) and the reason for taking:

_____

Does your child have an IEP, 504 service agreement or has he/she been enrolled in DART or any other early intervention program? If yes, please explain:

_____

I give my consent for the release of the above information to any staff members who need to be informed to maintain my child's health and safety.

Parent/Guardian

Signature_____Date_____