HEALTH HISTORY

Students Name_____ Date of Birth_____

Does your child have (Y or N)_____Diabetes _____Asthma _____Headache

_____Seasonal allergies ____Heart Problems ____ADD/ADHD ____Kidney Problems

_____Stomach Problems _____Irritable Bowel _____Breathing Problems

_____Medication allergy _____Allergic reaction requiring an Epipen

_____Allergy to stinging insects _____Other (Please Name)_____

Comments_____

List medication allergies:

	NAME OF MEDICINE	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

List food allergies:

	NAME OF FOOD	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

List prescription medication your child takes:

	Name of medicine	Strength	Dose	When taken
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Name of Parent (Please Print)_____
Address of Parent_____
Telephone of parent_____ Cell _____

Signature of Parent/guardian_____
Date_____

If there are ever any changes in your child's medical history, please notify the school nurse in writing.

10/2/11