

STUDENT HEALTH FORM

KINDERGARTEN THROUGH TWELFTH GRADE



Please complete the following information which will be made available to the school nurse and school personnel. Please relate any appropriate concerns that may affect your child's learning abilities to the principal and the applicant's teacher(s).

Name of Student _____ Date of Birth _____
Last First Middle

Father's Name _____ Mother's Name _____

Current Physician _____ Office Number _____

Current Dentist _____ Office Number _____

Has the applicant been diagnosed with ADD or ADHD? Yes No

Has the applicant been diagnosed with a Learning Disability? Yes No If yes, please explain _____

Has the applicant been diagnosed with a Physical Disability? Yes No If yes, please explain _____

HEALTH CONDITIONS (Please check if any of the following apply to your child).

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Spinal Curvature | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Allergies or hay fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea (frequent) | <input type="checkbox"/> Skin Rashes (frequent) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Stool Soiling |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Throat Infections (frequent) |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Tics/Nervous Twitches |
| <input type="checkbox"/> Birth or Congenital Malformation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Malformation | <input type="checkbox"/> Hepatitis (circle) A B C | <input type="checkbox"/> Wetting (daytime/nighttime) |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Learning Disability | |
| <input type="checkbox"/> Constipation (frequent) | <input type="checkbox"/> Meningitis or Encephalitis | |

If you checked any of the above, please explain. _____

Date of last tetanus shot _____ Does your child wear glasses or contact lenses? Yes No

Does your child have frequent ear infections? Yes No Has your child had any loss of hearing? Yes No

Does your child have any known allergies? Yes No If yes, please explain type and reaction. _____

Has your child had any severe injuries or illnesses? Yes No If yes, please explain _____

Has your child been hospitalized or had any surgeries? Yes No If yes, please explain _____

Is the student presently taking any medication? Yes No If yes, please list name(s) of medication(s) _____

Dosage _____ Milligrams _____ Frequency/day _____